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SUMMARY

Montana Governor's Conference on Health Care Systems

Helena, Montana

April 17 and 18, 1970

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summary of the

MONTANA GOVERNOR'S CONFERENCE ON HEALTH CARE SYSTEMS

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This conference was sponsored jointly by the Montana Regional Medical Program, Dr. Sidney C. Pratt, Director, Great Falls, Montana; Montana's Comprehensive Health Planning Program, Robert R. Johnson, Director, State Department of Health, Helena, Montana and a Montana Planning Committee* representing Consumers, Providers, and Insurers of health care. It was made possible under a contract (#HSM-110-69-433) between the Department of Health, Education and Welfare (Health Services and Mental Health Administration) and the University of Colorado's Center for Labor Education and Research.

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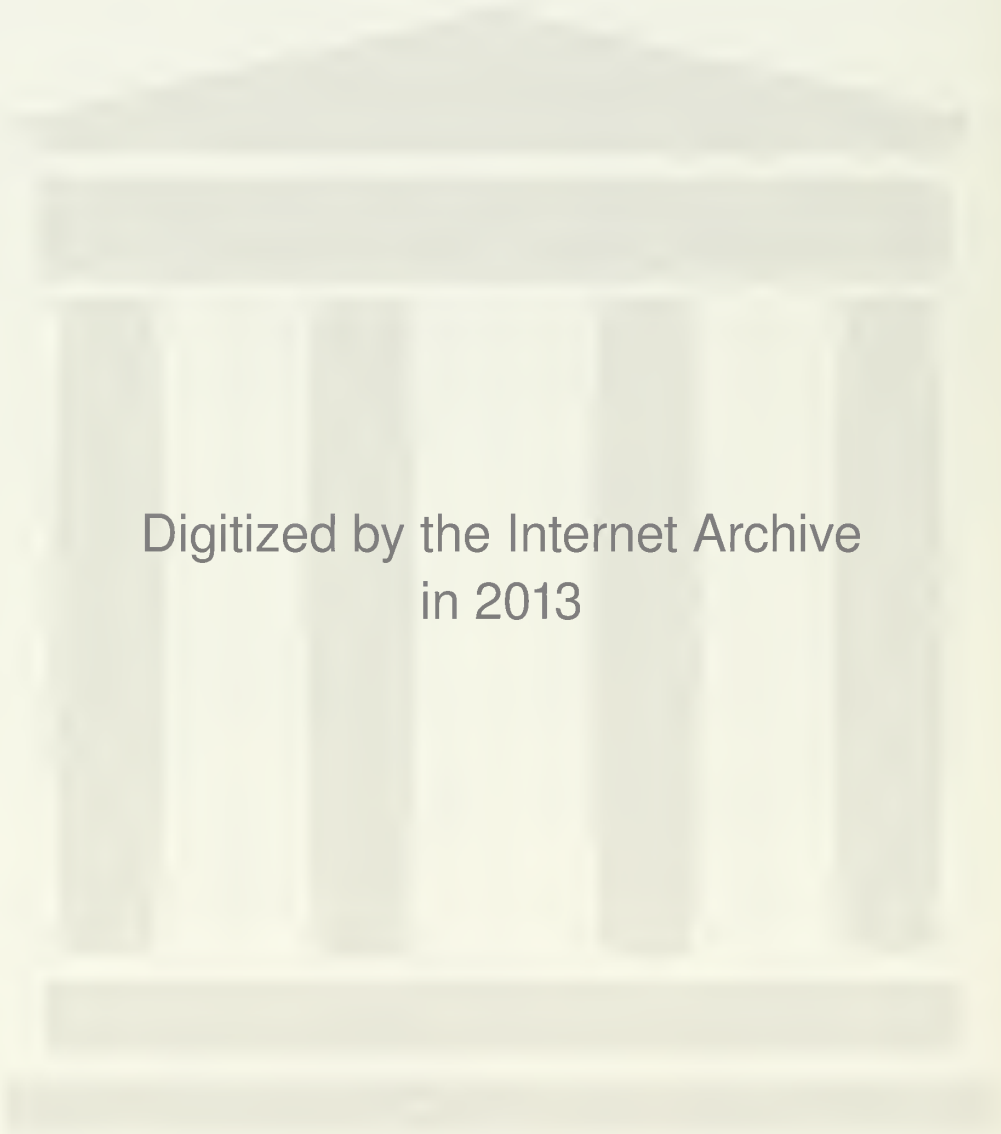
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TABLE OF CONTENTS

Frontispiece 1

Table of Contents. 2

Introduction 3

Program. 4

Welcome: Lieutenant Governor Thomas Judge 5

Keynote: "Challenges in Health Care"- John Hogness, M.D. 7

Panel: "The Status of Health Care in Montana"

-The Consumers of Medical Care - James Kent. 14

-The Suppliers of Health Care - John Strizich, M.D.. . . . 17

-Existing Health Care Facilities - Fred K. Holbrook. . . . 22

-How is Health Care Paid for in Montana?
Jack R. Carlson 26

"The Nation's Growing Concern About Health"
Congressman John Melcher. 28

"A 'Model' Proposal for Montana"
Walter H. Uphoff. 31

"The Pros and Cons of National Health Insurance"

Chairman: John S. Anderson, M.D.. 38
Speakers: Max W. Fine 39
Drew M. Peterson, M.D.. 48

Reports from Discussion Groups 55

"How Might the Prepaid Group Practice Concept Be Adapted as a 'Dual Choice' in Montana?"

Speaker: Maurice J. McKay 61
Discussant: Walter H. Uphoff. 66

Questions and Answers. 69

Summary and Evaluation: Sidney C. Pratt, M.D. 74

Conference Speakers and Participants 76

INTRODUCTION

The Montana Governor's Conference on Health Care Systems, held in Helena, Montana, April 17-18, 1970, brought together representatives from consumers, providers, and insurers of health care to hear speakers from within and outside the state discuss various aspects of health care in the state and the nation. The presentations made by the speakers and panelists stimulated thoughtful questions and contributed to lively participation in the discussion groups.

The growing awareness that we face a crisis in health care characterized by both escalating costs and shortages in health manpower and facilities has contributed to an increasing concern about how to develop more adequate and economical health care systems. The presentations and discussions at the Governor's Conference helped bring the health problems of Montana into sharper focus.

It is generally recognized that if society does not provide adequate medical care, it will pay indirectly, through more absenteeism on the job, lower productivity, higher welfare costs, etc. Whatever programs for better health care are developed must take into account the legitimate interest of consumers, providers, and insurers of health care if they are to gain enough support to function successfully.

The conference program was planned in cooperation with a Montana committee designated at a larger pre-conference planning session in Helena on September 17, 1969. Thanks to the Planning Committee, the speakers, panelists, and the conference participants, the meeting was a milestone toward developing better health care for the people of Montana.

The statements which follow were transcribed and edited from the tape-recorded presentations at the conference. In editing the materials, every effort was made to preserve the content and spirit of what was said by each speaker. The editor did assume the responsibility for editing the remarks and he hopes this summary accurately reflects what was said at the conference.

It is hoped that these proceedings will be helpful to those who attended the conference and to those involved in formulating policies and programs, both voluntary and legislative, designed to provide good health care for the people of Montana.

Walter H. Uphoff

MONTANA GOVERNOR'S CONFERENCE ON HEALTH CARE SYSTEMS

PROGRAM

Friday, April 17

8:00 a.m. *Registration*

9:00 a.m. *Welcome:* Lt. Gov. Thomas Judge

9:15 a.m. *Keynote: Challenges in Health Care*
Chairman: Sidney C. Pratt, M.D.
Speaker: John Hogness, M.D.

10:00 a.m. Coffee

10:15 a.m. *Panel: The Status of Health Care in Montana*

"The Consumers of Medical Care" — James Kent

"The Suppliers of Health Care" — John Strizich, M.D.

"Existing Health Care Facilities" — Fred K. Holbrook

"How Is Health Care Paid for in Montana?" — Jack R. Carlson

12:15 p.m. Luncheon

1:15-2:00 p.m. *The Nation's Growing Concern About Health*
Chairman: Lt. Gov. Thomas Judge
Speaker: Hon. John Melcher, Congressman, Eastern Montana District

2:15 p.m. *A "Model" Proposal for Montana* — Walter H. Uphoff

2:45 p.m. *Coffee*

PROGRAM

3:15-5:00 p.m. *Discussion Groups*

To identify health problems encountered by:

1. Business and Industry
2. Dentists
3. Disadvantaged (Low Income)
4. Farmers (Farm Organizations)
5. Government (Legislators, County Commissioners, Govt. Agencies)
6. Indians
7. Insurance Industry
8. Hospital & Extended Care Facilities
9. Physicians & Paramedical Personnel
10. Workers (Labor Unions)

6:30 p.m. *Dinner*

"The Pros and Cons of National Health Insurance"
Chairman: John S. Anderson, M.D.
Speakers: Max W. Fine,
Drew M. Petersen, M.D.

Saturday, April 18

8:45 a.m. *How Do Conference Participants View Health Care in Montana?*
Reports from Discussion Groups

10:30 a.m. *Coffee*

11:00 a.m. *How Might the Prepaid Group Practice Concept Be Adapted as a "Dual Choice" in Montana?*
Speaker: Maurice J. McKay
Discussant: Walter H. Uphoff

12:00 noon *Open Lunch*

1:30 p.m. *Questions and Answers*
Conference Speakers and Participants

2:30-3:00 p.m. *Summary and Evaluation*
Sidney C. Pratt, M.D.

WELCOME

by

Thomas L. Judge
Lieutenant Governor
State of Montana

This is an exceedingly challenging time for a conference on health care, both in Montana and nationally. Twenty-five percent of all Americans live in rural areas. In terms of health care and health care facilities, these people are, truly, the "forgotten Americans." Far too often, the health care they receive is too little, too antiquated and too late. Often these rural Americans are denied completely the "day to day" access to care which many of us take for granted. I am sure that the lack of essential services of health care in so much of rural America has contributed greatly to the despair which eventually forced so many rural families into our already teeming cities where they are condemned to lives of under-education, under-employment--lives of what Michael Harrington called "The Invisible America." Certainly Montana is a microcosm of this national scene.

One small Montana community has just announced that it is hiring a doctor for the first time in three years, to serve an area the size of Rhode Island. As the unfortunate decline of the family farm, as we know it, continues; as consolidation of facilities at all levels grows; as there is a growing dependence on services beyond the immediate living area, with its accompanying maladjustments in community services; there is bound to be a contemporary crisis. We have a continuing challenge to both the health care facilities and the medical professions in Montana. Montana's historic response to these kinds of medical needs has provided an impressive and encouraging background for future activity and yet it may well be time to combine in our future health care planning the intensely individualistic interest of the sons of the soil, the interests of the rugged general practitioner and a new dimension of community involvement.

I was pleased to participate in the dedication of the Conrad Community Hospital last year and I was deeply impressed by the degree of community involvement in that venture. I believe that such community involvement is one of the keys to the health needs of our growing, rural Montana communities. But more than that is needed. There is a need for sound, substantial and sincere model plans for Montana. Health care facilities and professionals in that field need far greater funding to meet our rural and urban needs. Any discussion of health care must almost begin and end with the subject of "money." As a legislator who sponsored implementation of the Kerr-Mills Medicaid Programs in Montana, I can assure you that this was a very difficult fight. Our per capita expenditures for health have ranked well below the national average and the average of the Western states. Yet the cost of health care is staggering. Even when the federal government pays 65% of the costs, it is very difficult to find state "matching funds" in a sparsely populated state like Montana, with a limited tax base. I believe that the only answer is federal support. I hope that the Vietnam War can be brought to a very speedy conclusion and that funds now being spent on weapons to "end" life can be diverted to "preserve" life. It is also encouraging to see private

funding for health care emerging in some parts of the country. Many foundations and corporations are willing to aid communities in health care funding and planning. The Sears Roebuck Community Medical Assistance Plan is an excellent case in point. Some of these plans will be discussed this afternoon by your speakers. Hopefully, we might also develop a workable plan for health care facilities for Montana's "borderline" wage earners.

In a time of rising costs in all phases of health care, the borderline or "medically indigent," as they are called, are in a particularly difficult position. Most of them earn too much to be eligible for public assistance care and most of them are too proud to seek this kind of care anyway, yet they spend a disproportionate percentage of their incomes for treatment of the same illnesses as a wage earner in a higher salary bracket. This is especially true and unfortunate in homes with only one parent. The Medicaid program in Montana must be expanded to include those who have enough income to meet their basic daily needs, but not enough to provide for medical expenses, or it must be replaced by federal health insurance for all of the poor. It is a shame that children who are in need of medical care must go without it if the family's income is insufficient to meet the youngster's medical needs but too high to qualify for Aid to Dependent Children (ADC). These children should also be included under the Medicaid program. Speaking about Medicaid as a whole, its system of eligibility, loose budgeting, crazy-quilt pattern of benefits and failure to set standards of care was fashioned from old-fashioned, "welfare-oriented" programs. The promise of Medicaid that some care at least would be available to all who needed it has vanished into the obscurity of state determination of eligibility and parsimony of state determination of solvency. I do not believe you should end this assembly without calling for legislative support for health care.

Montana's health care professions need help in bringing about a modern, enlightened climate for improved health care. Rules and procedures should be streamlined for more economic and efficient operation. National policies and practices toward the American Indian have continued to be one of the most shameful stains in American history. Our Indians are entitled to good medical care but they have great difficulty receiving it unless they live on or return to the reservation. The Public Health Service Program for Indian Health Care should be expanded to provide adequate funds for medical care for at least five years after they leave the reservation. The need for better health care is awesome: in our rural communities, for wage earners, for the poor, for the young, for the elderly, and, especially, for Montana's Indian community. There are imposing problems ahead but in the face of dismay there can be dedication. Montana's historically responsible health care professions can move anew to accept these challenges, to create the kind of society we said we were committed to when this nation was formed. Nothing is more basic than a person's health. One of the best investments a society can make, both public and private, is one that insures the maximum opportunity for each individual to achieve his greatest potential. Good health is a basic requirement for attaining this goal. It is in that spirit that I welcome you to this conference, I applaud your interest and I wish you well. Thank you very much.

KEYNOTE: CHALLENGES IN HEALTH CARE

by

John Hogness, M.D.

Executive Vice-President
University of Washington

Dr. Pratt, Lt. Governor Judge, ladies and gentlemen, it is a very distinct pleasure for me to be here. I was glad to be asked to talk on "Challenges in Health Care". I realize that this is the Montana Governor's Conference on Health Care Systems and I shall devote some of my remarks to the problems related to health care systems. I would like to give you a general backround for the discussions which will follow today and tomorrow, a broad "brush painting", if you will, of the situation nationally rather than locally. It is clear that there is a crisis in health care in this country, a crisis in our health care system. Changes in that system are coming extraordinarily rapidly and we can anticipate many such changes over the course of the next few years. There is also a crisis in the cost of health care and a crisis in the availability of services as Lt. Governor Judge just mentioned. I realize that this conference is primarily devoted to "systems" of health care. I think we must bear in mind, however, when considering the health care of the nation and this state that it is impossible to think of adequate health care without considering housing, nutrition and many other factors. For no revision of the system of health care can bring good health to all of our people if these other factors are ignored. It becomes, then, not only a matter of considering our health care systems, but also a matter of determining priorities and making decisions. In other words, where do we put our dollars?

We are also confronted with a matter of attitudes and some of these must be changed if we are to make progress in health care. In most of our thoughts and actions, in the public sector as well as the private sector, among health professionals as well as among laymen, we have been "disease" oriented; we have not been "health" oriented. We go to the doctor because we are sick, not to stay well. We pay for cures, not for prevention. We will need to re-orient our thinking to a very significant degree in this regard as well as in many others. We are confronted with difficult choices; for example: Is it going to be more important for us to invest large sums of money, both public and private, in further developing and financing artificial heart programs or should we put that same amount of money into massive campaigns against smoking? Where will the most significant "payoff" be? We are at a point in our economy and in the development of medical care where we can not afford all of the things that are ultimately possible for the preservation of life for all of the people. It will be necessary to make some value judgements in this very difficult area. We must ask, then, what are our priorities and who should set these priorities?

Let us turn now, if we may, to a review of the present status of our health care system. First, I think it is appropriate to look at the quality of care. We have made tremendous strides in improving the quality of health care. Our infant mortality is the lowest ever. We have virtually eradicated most of the infectious diseases. Death from heart disease decreased 20% in the last four years. We have better antibiotics, better buildings in which to render health care and we do much better health research in the fields of biology and health than we ever have in the past. We like to say we have the best medical care in the world, but this is simply not true. We have, I think, without question, the best-trained physicians, the best-trained nurses, the best-trained dentists and other health professionals and hospital administrators. We are capable of providing the very best quality of medical care anywhere but only to a portion of our population. Inspite of all this, our health statistics are embarassing in some areas. We rank approximately 14th in the world in infant mortality, 18th in male and 11th in female life expectancy. So there is no reason for complacency.

This is a conference on health care systems. Can we define what we mean by health care systems? This phrase means different things to different people. To some it means the system of payment, of financing health care. To others it means the system of organization of providers, the organization of groups of physicians, dentists, etc. To still others it means the organization of the system of facilities in which health care is rendered. And, finally, it must include the system of training-- the manpower for health care. We are really talking about a complex of sub-systems, of financing plans, of organizations of providers, organizations of facilities and systems for training health manpower and health professionals. As a matter of fact, we have at present, no organization of health care systems, but, rather, a mosaic of public and private programs, organizations and facilities.

Let us try to identify some of the problems of health care systems. Let us look first at costs and financing of health care. The costs of medical care and health care are going up 12-13% per year. One day in the hospital costs between $100.00 and $200.00 in many parts of this country and the costs are continuing to rise. If we looked at the total disposition of national resources, we are spending almost 7% of our Gross National Product for health at the present time. This is second only to our budget for defense. In the year 1970 we will spend an estimated $64 billion, 40% of this in the public sector and 60% of this in the private sector. In the public sector, the federal outlay is estimated to be 28% and the state outlay 12%. Expenditures for Medicaid this year amounted to $2.6 billion from federal money and $2.6 billion of state money. In 1970 the total budget for the Department of Health, Education and Welfare is approximately $50 billion, second only to, again, the Department of Defense. Nevertheless, with major expenditures like this and with major efforts to extend health care services to disadvantaged groups in our population, there are still serious needs and inequities. Take, for example, the group commonly referred to as the "poor" and the "near poor", i.e., all the families of four making less than $85.00 per week. These groups amount to 40 million persons or one-fifth of our population. Now, Medicaid was designed to provide health services for the indigent and medically

indigent. Medicaid reached 8 million persons in 1969 and may reach 9 million in 1970--one-fourth of the groups called the "poor" and "near poor".

Medicare has removed much of the burden of health care for the poor and the aged. Nevertheless, in 1967 Medicare covered only 45% of the health expenditures of the aged. Public programs reach a minority of the "poor" and "near poor" and there is some question as to the degree of coverage for those who do receive the benefits. What about private insurance? 80-85% of the population have some form of insurance. The portion of the population covered varies directly with income levels. Of those persons with incomes of less than $3,000 per year, less than one-third have any insurance whatsoever, public or private. Thus, about 30 million persons under the age of 65 are without any kind of health insurance. And we have not even discussed the coverage of the people just above this economic level. Our system of financing has been justly criticized because there are a number of overlapping interests and because there is an inadequate coverage for many groups in our population. In the matter of overlapping interests, there is the matter of unevenness of standards, unevenness of quality and conflicting purposes. The same can be also said about our federal programs. We have numerous agencies and programs involved in health care such as Medicare; Medicaid; OEO; Neighborhood Health Centers; Children's Bureau; Vocational Rehabilitation; Veterans Administration; The Public Health Service; the Indian Health Services, etc--many overlapping, inconsistent and uncoordinated programs. We have multiple private insurance programs, these are also overlapping, inconsistent and have varying standards. This can hardly be called an "organized system" of services. We must admit that in this country, as in many other countries, we have a disjointed, conglomerate of individual units, individual internal organizational patterns--very few tied to one another.

Let us turn now to the system of provision of services. We must all be familiar with the phrase "cottage industry". Any businessman running a large corporation would throw up his hands in horror if he examined the way health care is delivered. In my judgement, the system of organized medical practice is out-of-date and has not responded adequately to medical progress, social change, growing specialization and growing urbanization. Needless to say, the problems of the "rural" communities are also extraordinarily difficult to meet with the present delivery system. There are many reasons for the present patterns of operation. They are related to such concepts as the "doctor-patient relationship", "fee for service", "freedom of choice" of physician and dentist and, of course, the individuality and independent characteristics of physicians and other providers of health care which we have encouraged in the past and still do. It is fair to say then that we have not concentrated enough on the search for greater productivity or the development of organizational patterns which would be more economical and more time-saving. At the present, although there are some exceptions, there is no significant development of inter-relationships between groups. There is inadequate use of allied health personnel. The "health care team" does not really function as much of a team. One example of inefficiency in our medical care system is the way the trained surgeon is used. I don't mean to imply that the individual surgeon is inefficient in any particular operation he performs, but the utilization of most surgeons in this country is inefficient. In 1966 about 11 million

surgical procedures of all kinds were performed in the hospitals of this country. At that time there were about 50,000 physicians who listed their primary specialty as surgery. Even if we presumed that all operations in hospitals were done by specialists, and, certainly, this is not the case, nor should it be, but even if we presumed that, this would amount to an average work-load of 220 operations per surgeon peryear. This is less than one per day and that includes some simple operations.

We have not only the problem of organization, but also the problem of entry into the system. Many people can not afford to get into the system, and many other people don't even know how to get into the health care system. And the sad fact is that if all the people in this country who need medical care could get into the health care system, the system, at present, couldn't possibly handle them. This brings us to the matter of health manpower. There is in this country, at the present time, a tremendous shortage of physicians and this problem is increasing, despite very significant efforts on the part of medical schools in the last decade to increase the number of physicians. The same thing can be also said of nurses, dentists, etc. There is a need for more personnel and also a need for team organization. There is a need for greater sharing of patient care responsibility and better definition of the responsibility of each health professional.

Let us turn now to some suggestions for progress and change. There is definitely on the horizon, for the immediate future, some form of a universal national health care payment system. "Universal National Health Insurance", if you will, backed by federal financing. The mechanism of federal financing or the mechanism for co-insurance has not been worked out yet. There is little question that some kind of national health insurance coverage is coming and is coming soon. At the present time some eight or nine proposals of varying kinds with different approaches to the problem have already been made. There is the "Fulton Bill" which has the backing of the American Medical Association. This is, essentially, a "tax credit" program related to levels of income. In recent months we have heard about numerous proposals for national health insurance plans. The National Conference of Governors recommended a study of universal national health insurance similar to one known as the"Rockefeller Plan". Senators Javits and Magnuson have developed a bill and the AFL-CIO as well as the Committee for National Health Insurance, formerly known as Walter Reuther's Committee of One Hundred, are actively promoting discussion in this area. The American Medical Association and the American Hospital Association have made proposals as have individual economists and health experts and political leaders.

For purposes of simplification, you can take all of these proposals and classify them in four general types. The first type is the "tax credit" plan. Under such a plan, federal income tax credits would be provided for the purchase of voluntary health insurance, the amount of tax credit determined by the income of the tax payer, i.e., the greatest credit would be given to the individuals with the lowest incomes. The next group of proposals can be called the "social insurance set". These advocate an extension of the Medicare concept, under Social Security, to other portions of the population. These call for some form

of combined employer-employee and federal government participation in providing the funds. Another group of proposals such as the "Rockefeller Plan" call for employer-employee financing arrangements with private insurance programs and a federal law requiring employers to establish a program and making the program subject to certain federal standards. Still another approach calls for "major risk" insurance provided by the federal government on a sliding scale according to income. Suppose that the "major risk" insurance provided that no individual should be required to spend more than 10% of his income for health care. Under such a proposal, the federal government would pick up the expenses over and above that set amount.

In considering systems for financing health care, it is important to remember certain basic requirements and criteria: 1) a system should take care of all the people; 2) it is important that the system of payment for care not lock us in to any existing delivery system, that is, require that the existing delivery system be the only one that can be utilized; 3) a system should keep operational costs down, be easily administered and involve a minimum of "paper work". Therefore, if we need to put together a package, we need to do it in the least expensive way and if there must be a limitation on the services offered, it should be the simplest possible form of limitation. It is much simpler to limit the kinds of procedures than to limit the length of stay in hospitals because the latter requires much more record-keeping. Finally, a basic requirement of the system is that is must have incentives in it and it must avoid a large tax increase, particularly at this time. I would suspect that the first stage of any new system will probably combine a contributory system of employer-employee contributions for the working population; develop prepaid contribution systems for the intermittently employed and will end up having the federal government pay the premium for the unemployed from the general tax revenue. The possibility of putting the premiums from all of these systems into one "pot" and administering them through a central agency certainly exists and it would appear that since people will not be able to afford completely comprehensive health care, we will probably end up with an initial basic minimal package with options for additional coverage for those who can afford or negotiate them. This is my guess as to the kind of initial system that will evolve. Any system that is devised however, must have built-in controls. The rising costs in the health industry are not subject to normal market conditions; the balances of a free market do not exist in this circumstance. There is an economy of scarcity. The patient is relatively uninformed as to quality. There is no good way for him to measure quality. The seller, by nature of the art, determines what the patient shall buy. With the federal and state governments pumping money into the health system both in research and health care delivery, the relationship between supply of funds and the supply of medical personnel and facilities becomes even more unbalanced. It will not be a normal supply and demand market. This calls for the development of utilization review, quality controls and cost controls. Such controls, I believe, very firmly, should be instituted by the providers of health care because if they are not instituted by the providers they will, of necessity, be instituted from outside.

Now what about the matter of efficiency? I am sure it is possible to develop greater efficiencies in hospitals and this obviously must come. Perhaps we don't have enough incentives for efficiency and money-saving procedures in hospitals. What about developing a system whereby not only the hospital managers, but also those using the hospitals, will get a "bonus" when costs are kept down. Couldn't we reimburse groups of similar hospitals on a comparable basis and thus stimulate greater efficiency on the part of the less efficient hospitals? This would provide funds for the more efficient hospitals to expand their facilities and the quality of their services. What about reimbursing all hospitals on a "per diem" basis, negotiated in advance, rather than on a "fee for service" basis after the fact? This is already going into effect in some states in the Blue Cross organization. We need a rational organization of the hospital industry. We should have systems of hospitals, extended care facilities and nursing homes all under a single management. We should have a group of hospitals and, perhaps, even clinic facilities and nursing home facilities under one common management for the sake of efficiency.

And, of course, we need to increase the efficiency of medical practice as well. I think this can be done, in part, through the development of new types of health personnel, of greater utilization of people with less training, who perform certain functions that the physician and dentist now performs. We need to train teams to really work together. There are other ways inwhich the delivery of medicine can be improved. You will hear these discussed on the remainder of the program today and tomorrow.

Now what about the problem of the location of physicians and other health personnel in areas where shortages exist such as some rural areas and urban ghettoes. Should we not provide significant financial incentives for individuals to locate in these areas? Should we, perhaps, consider a "universal national service system" for health professionals, men and women and not just physicians, whereby a physician, for example, could serve either in the military or on an Indian reservation or in remote rural areas of the country or in urban ghettoes? Is this something to be considered? If so, should it be compulsory or should it be voluntary? Certainly, there is need for a vast increase in our health care manpower right now. Public policy should make it possible for medical schools and nursing schools to double their output as soon as possible. We need federal and state support with built-in incentives for shortening the training periods, consistent with the maintenance of quality, not just for physicians, but also for nurses and dentists. With the shortages in health manpower there is a great need for accelerated programs of training and for making the public aware of the need to, at times, accept alternatives to the "super ideal" forms of care available to those who can afford it and are available to get it. The physician is currently trained to do everything possible, regardless of the cost. We can no longer approach medicine in this way. This is a fairly blunt statement, just as in the matter of implanting artificial hearts in every patient who has a serious heart defect or heart disease versus putting that amount of money into other programs which might benefit more people. We have to make choices and establish priorities. This is a disturbing but, nevertheless, vital consideration and the need for priorities must be faced immediately.

I have tried to summarize the types of systems that we refer to as "health care systems". I have tried to identify some of the problems and some of the suggested solutions. We are very close to a new era in health care in the United States. Many changes are coming to all aspects of the health care system. It will require a great deal of adjustment on the part of those providing health care and on the part of the consumers. But in the long run this will result in better health care at lower costs or, at least, in a smaller increase in costs for all the people. In looking at the program it is obvious that this conference is bound to be a stimulating one and I know it will be successful. Thank you very much for asking me to participate.

Dr. Pratt: Thank you very much, Dr. Hogness. You have done a good job of setting the tone for this conference. We are grateful for your forthright remarks.

PANEL:

THE STATUS OF HEALTH CARE IN MONTANA

Dr. Sidney C. Pratt, Chairman

Dr. Pratt: As you can tell from the program, the purpose of this conference is to examine the status of health care in Montana from the vantage point of consumers, providers and insurers of health care and then to discuss what might be done to improve health care delivery. It is with this in mind that we start our first panel. Our four panelists are: Jack R. Carlson, the Director of the Division of Medical Assistance, Montana Department of Public Welfare; Fred K. Holbrook, Administrator, Montana Deaconess Hospital in Great Falls; James Kent of the Foundation for Urban and Neighborhood Development in Denver; and Dr. John Strizich, member of the Montana State Board of Institutions. They will all discuss health care as they see its status and its problems.

James Kent: I do appreciate having the opportunity to speak here. I have had occasion to do some work in Montana during the last two years, especially with low-income groups and poverty groups. I am to discuss the problem of medical care as seen by consumers.

If we are to get health care to the consumer, we must understand the consumers and the consumers must understand the system. We must begin to understand the environment in which the consumer lives and how he functions from day to day. We hear much talk about how to spend medical dollars and how to reorganize our medical systems. There is much talk in Washington about the need for changes in our health care system. Yet unless we also look at the other end of the system, where consumers seek care, where children die, where premature pregnancies occur, surrounded by bad housing and inadequate welfare supports, we can't understand what is needed for a proper health environment. We must look at health care as an agent of change. We heard Dr. Hogness say that, "Health care is disease oriented." Under these circumstances we cannot expect health programs to play much of a role as an agent for change. We must think of ways of organizing people to deal with other problems that confront them in their daily lives besides health--things such as housing, welfare, etc.

One thing I would like to caution you about is that we should not get too caught up in systems and statistics. For example, Missoula, Montana has one doctor for every 619 persons, according to statistics, but the majority of the doctors in Missoula are specialists. Many consumers do not know how to get adequate care from whatever health system exists in their community. The marginal consumer really doesn't detach health from other aspects of his life. Health is just an interrelated aspect of the problem of living. The health system that the consumer will be using must emerge out of his own environment. Thus, we must really understand that environment, so we can accommodate that

system to many different types of communities and areas in Montana. If there is going to be one system that everyone can "plug into," we must consider the physical, economic and social variables when designing a workable system.

When you look at where people live, the locations of their shopping areas within a city like Helena or Missoula, you find neighborhoods cut off by roads and isolated. Although the distance between the services and the resident population may only be three or four blocks, the fact that there is a physical barrier must be taken into account in your health planning. The poor, the unemployed, the person on welfare can't really control many aspects of his life, except ones that he can design himself. We must understand the environment of the consumer. If you are on welfare, someone controls your income. If you're on Medicaid someone really controls your health; there is no participation. If you are in school someone controls it because it is not really a neighborhood school but one controlled by the administration uptown. There are very few places where we find meaningful consumer participation.

We must begin to think of the consumers of health care as key decision makers in how health care is designed and how health care is going to be brought into their areas--not necessarily how it is going to be administered, but how it is going to be designed. By looking at the environment we begin to see where we're going and what's happening. The other thing we must look at is how people manage their health care from day to day. We find, for instance, that there is a "health caretaker" system in many urban and rural areas. Let me describe it briefly: If you look at what people do to manage their health crises, you will find that many rely on a "health caretaker" or a "folk practitioner" for advice. They often use herbs and "folk medicine" remedies. You have to understand what people do now for health care in order to devise a plan that can better serve their needs. Many times they already have a very elaborately organized medical system which relies on herbs and the physical care of their own "practitioners."

The consumers are managing somehow, and we need to find out more about how they are handling that environment so that we can make more sense out of it when it comes to designing a health system. Otherwise we are going to put more money in and yet have very little impact on the quality and kind of care available to consumers. I don't think our health systems will really change much unless the consumer does have a voice in the decision-making process. After all, the consumer should be able to tell you something about whether you have a good health care system or not.

We must design a system that's accountable to the consumer, to the person who is the direct recipient of the health care, rather than primarily to vested interest groups. Accountability, somehow, has to shift to the patient. If your concept of health care includes preventive health as well as the treatment of disease, you begin to deal with the consumer and his everyday problems. We found in our work with the health programs

in Denver and in some of the other areas we have been involved in that you have to be able to enter a person's life on his basis, whatever it may be. You may find that a person is having a legal crisis when you come to deal with a health problem. Unless you can at least make some suggestion on where he can get legal aid, you are not likely to be completely accepted with any health care you have to offer. Our systems of welfare, health, education, etc. have developed a very elaborate but pluralistic method which keeps passing responsibility to other fragmented systems in society, and the person who is at the receiving end can't make any sense out of it. What we are talking about is looking at health as part of the total life process and not just a service that's provided when you are very, very sick or when you're dying.

When working with the Neighborhood Health Center in Denver, I found in the Spanish-American area that when very, very sick persons were sent to Denver General Hospital it was assumed to be the "will of God," according to that culture, if the person recovered and the doctor's fault if he died. So you can't win, unless you can understand what's happening to the people in the area. Here is an example of the way language can cause problems when there are language and cultural differences. A doctor may prescribe a teaspoon of medicine after each meal, but the patient may not even know what a "teaspoon" is when translated into Spanish and even if he does, but eats only one meal a day, that dosage will not be appropriate. There are many such factors in everyday occurrences that will defeat any health system you're talking about unless the providers really understand the environment of the consumer, how he manages, how he uses language, how he has to cope with a cold house in the winter time in Anaconda. If his child dies of overexposure, he is concerned about life and death, not just health.

What I am trying to convey here is that we have to be concerned with the total environment of the individual, his peer group, his neighborhood and his family. At two o'clock in the morning, who do people call if they have trouble? Find out who those people are and you'll begin to understand how these people plug into their "natural system" when the professionals aren't available--e.g., on weekends and before eight and after five. You may find that in some neighborhoods many people get up at 10 o'clock in the morning or 11 o'clock, and stay up later in the evening. If everyone gets up at 11 o'clock, what are we doing opening our health facilities at eight o'clock? Most people who work in the health field agree that prenatal care is important but how are you going to convince a woman of this who has had three healthy children without prenatal care? If we can provide help in some area of her life, such as finding employment, for example, she may begin to see health as a part of a very good experience.

I would like to conclude by saying that I want to look at health care with the consumers in terms of an action model, not as a disease-oriented service model. If we take this approach we see that many of the problems such as high costs may be solved somewhere outside the health field, through better jobs, better housing, etc. We are

concerned with the total environment. Let me explain a little bit of that philosophy. Our FUND organization (Foundation for Urban and Neighborhood Development) is hopefully a new brand of organization for social services. It grew out of the needs of the environment and had no prior bureaucratic ideology. We went out to observe and describe what was happening to people, and then helped them to solve their problems. We've got to think in terms of new organizational techniques. I think consumers must have a key role, if not the dominant role in managing future health systems. Only they really know how to perceive their health needs in their world. We, as outsiders, really can't perceive a consumer's need in a Harlem ghetto or in northern Missoula.

We should also think of many new roles that consumers can play in the field of health care delivery. In Colorado we already have a licensed pediatric nurse practitioner. I am sure that other new careers will be developed in the health field. In West Virginia doctors in centralized locations, with access to closed circuit TV, have trained persons to diagnose sounds in a person's lungs so that a doctor doesn't have to travel fifty or sixty miles for every examination. Two new types of jobs were established in the Denver Neighborhood Health Centers. One was called the "neighborhood representative" and another the "family health counselor." At first these new jobs were seen as a threat by the nurses and social workers, but they were very exciting programs and it was eventually shown that they could be very supportive to the nurses and doctors.

We've got to find strength in the populations we're dealing with and show how a health system might help them develop power over their own lives. I have a very simple definition of power: "A person's ability to control, predict and participate in his environment." That's really all we're asking at the consumer end of the health care program.

John Strizich, M.D.: My concern is, of course, related to the problems of health care in the state of Montana. Montana is a big state. We have vast distances, a shortage of doctors and especially of general practitioners in many parts of the state. I have the feeling that our problems are somewhat different from the medical problems associated with the ghetto, but since I have no familiarity with those areas I will confine my remarks to the problems we have in our state at this time. I would agree that perhaps many of the systems for the delivery of health care which are available in this country could contribute something toward the solutions of our problems.

Someone has calculated that if we were to double the number of physicians turned out by our medical schools it would still take about 20 years to catch up with the demand for physicians throughout the country. It is easy to say, "Well let's turn out twice as many doctors," but there are tremendous problems of educating the physicians and tremendous amounts of money are needed for building and expanding medical schools. We don't even have enough well-qualified medical educators at the present time and where are we going to find double that

number even if we could suddenly produce the buildings and the other facilities necessary to double the enrollment in our medical schools? As I see it there are three kinds of problems related to the health needs of Montana. One kind is associated with the larger medical community in the state; another is associated with the problems of satellite medical communities; and the third is related to the individual care of the individual patient.

Before I talk about these problems and my notions about them, I would like to say a few words about the problems related to the physician's operating at maximum efficiency. First of all, most doctors have too large a patient load. Ideally the ratio of doctors to population might be one doctor for every 700-750 persons. In Montana the ratio is closer to one doctor for every 1200-1250 persons. The physician faces many problems related to continuing health and medical education. He must keep up in his own field but he also has the responsibility of educating his patients and his paramedical personnel. Let me cite an example in my own field. When I finished my medical education in internal medicine ten years ago and came back to Montana to practice, we had all had a certain amount of training in genetics, but it was regarded as an academic discipline. The tremendous knowledge explosion that has occurred in the field of genetics since that time virtually makes it mandatory for the doctor to go back into the basic genetic knowledge and attempt to become relatively current on the language geneticists use. Now why is genetics so important? As we learn more and more about the genetic basis of disease, the importance of genetic information becomes extremely great to the individual practitioner in everyday practice. The diabetic--a young diabetic boy or girl who is growing up in your practice--should be counseled as to the genetic possibilities of having diabetic children. The physician finds himself serving as a genetic counselor. When we deal with problems of the "recessive genetic diseases," particularly those related to abnormalities in blood cells, we should inform the patient that if the children receive such a gene from only one parent there is relatively little danger, but that if they receive it from both parents, many of them will be born with a catastrophic illness that will kill them before they get very old. This is just one illustration of the tremendous problems the physician faces every day in his efforts to remain current.

Another area where tremendous advancements have been made is in the treatment of the patient with a heart attack. Work sponsored by the Regional Medical programs has added new knowledge and skills for taking care of our patients, but this new knowledge and skill is not yet available to all our people. When we consider all the ancillary responsibilities the physician has to face at this time, including the requirements of the Joint Hospital Commission and all the paper work which must be done on a patient, I think you can see that the physician is a busy person. Then there are also additional responsibilities imposed by government programs and I am sure these responsibilities will be increased in the future. Utilization reviews on Medicare patients, hospitalized under Medicare either in the acute hospitals or in long-term facilities, make an additional demand on the doctor's time. I might add here that

even coming to this Governor's Conference on Health Care Systems, which--by the way--I consider important, is another obligation which takes doctors away from their primary function, which is still the care of sick patients.

Let me talk briefly now about the problems associated with the larger communities in the state. Helena provides an example of the problems that have been created by the great expansion of their capacity to care for sick people over the last ten years. A number of years ago, Helena had only five or six specialists. At the present time, there are 25 or 26 specialists. A great many of the people in the Helena area were going to other medical communities for complex problems but today they come to Helena. The presence of these doctors in Helena has increased the demand for medical and for hospital care. In the last several years this community has spent about 6 million dollars on improving its medical care facilities. This involved building an entirely new hospital; it involved the expansion of another general hospital; and, at the present time, we are also expanding a pediatric hospital in Helena.

When new information about coronary care units became available, a number of the doctors in Helena went for special training and the hospitals became stuck with another big and extensive responsibility. Several hundred thousand dollars were required for a coronary care unit. It required buying monitors and better types of X-ray facilities for better care of these people. Now what is the advantage of all this to the consumer in Helena? The average death rate from myocardial infarction in a general hospital, if the patient survives long enough to get into the hospital, is about 35%. The death rate in a well-run coronary care unit is about 20%. It is not likely that the percentage will drop much below 20 because in the cases where death results the chances are that too much heart tissue was already destroyed and there really isn't much that can be done in those cases. These are examples of the kinds of problems that the larger medical centers are facing.

In the satellite medical communities in the smaller towns, which cannot afford to establish the elaborate facilities I have been describing, one of our major problems is that of getting more doctors. One of the facts we must recognize is that when you train a physician in a multi-million dollar complex he will not be interested in taking out an appendix on a kitchen table. Many physicians are choosing to become specialists because the expansion in medical knowledge has made it extremely difficult to reach a degree of competency unless the man does limit his field. This is in no way intended to reflect on the group of superb general practitioners we have in the state nor on the younger men who are coming in as general practitioners. A great many of us, who are specializing, personally feel we can't cope with the great responsibilities of the general field of medicine and do a job in the fashion that we want to do it. I practice internal medicine. Internal medicine is, at this time, divided into approximately ten different sub-specialties. So in many respects, even the internist with three or four years of post-graduate training is in many respects a general practitioner because our field right now has at least ten different sub-specialties associated with it.

Perhaps one of the answers to getting more general practitioners into Montana might be to provide more adequate and better financing of the medical student. A number of my classmates in medical school had to drop out for financial reasons because of the great financial burden involved in getting a medical education. I believe you know that the state of Montana does subsidize some of our medical students but it does not subsidize enough of them. There are various government and school programs available to assist the medical student but they are simply not adequate and one is left to wonder how many good young men with capacities to be physicians lose their interest in going on over the long years it takes simply for financial reasons. I would like to see our state program expanded to subsidize all our Montana students in medical schools because I believe we will have a better chance of getting young doctors to this state if they have been raised in this state. To some extent we can thank the smog of Los Angeles and the smog of Chicago and the like because it does bring some doctors to our state.

Another way we could reduce some of the pressure on our medical care system is through better utilization of paramedical personnel throughout the state. It has been very gratifying to watch the nurses in our coronary care units develop as they have been given additional responsibilities. I am well aware of the law that does not permit them to practice medicine but I sometimes wonder about the wisdom of a law like this with many of our nurses. I also wonder about developing careers for the "physicians' assistants". I once raised this question with a nurse and she "went right up through the roof". She immediately thought of all the time she had spent as a professional and all of a sudden she was going to be an "assistant" again. This suggests that we will have to develop some new terminology for jobs as well as re-defining responsibilities. Experience in the military has shown that when persons with limited training are given additional responsibilities, they do develop skills and make a real contribution.

When we come down to the care of the individual patient we have to be concerned with problems of screening, of separating the well and the "worried well" from the sick and the early sick and making good use of screening procedures. The Public Health Service in Montana has had some limited experience in screening and testing people's blood sugar in various communities. Some form of this program is simply going to have to be inaugurated and expanded in the state of Montana. I have found, in my own practice, when screening people for diabetes, I will diagnose at least two cases of diabetes per month by routine screening procedures on a great many of the patients who come into my office. These procedures are relatively simple and should be more extensively used in the state of Montana because the long-term complications of diabetes are a tremendous social problem.

I don't mean to say that the screening procedures are perfect and I don't think any experienced physician would ever say that if you have a normal chemical profile, a normal chest X-ray, etc., that it necessarily follows that nothing then is wrong with you. Because I think all of us physicians find significant problems in patients who

are totally asymptomatic and who have totally normal blood studies and normal chest X-rays. One of the problems of treating the patient with high blood pressure is that he feels well and he can not understand why the doctor insists on prescribing expensive pills. All too often the first time the patient knows that he doesn't feel well is when he has had a stroke. In my experience about one out of every 700-800 patients will have an asymptomatic cancer. If you wait for this to develop a symptomatic lesion, the chances of saving the patient's life are markedly reduced. As has already been suggested, better communications is certainly one of the factors that could be helpful in improving medical care in Montana. We are already able to transmit EKG readings over the telephone wires and I feel it is desirable that the appropriate use of this technology be expanded. We also have the technology to transmit pictures through machines. How much time and money could we save if we transmitted X-ray pictures to a trained radiologist for evaluation?

One last point that I would like to mention is the problem of transportation. I had occasion to take care of a medical care facility in Vietnam several years ago where we transported wounded people in heliocopters from all parts of that country. I had been assigned to a large hospital ship anchored off-shore at Da Nang. This hospital ship had the facilities to perform practically every type of surgery I know of. They even did a bit of heart surgery on the ship, some of it on young, Vietnamese patients I was taking care of. Of course, most of our patients were men from the field who were brought in almost immediately after being wounded. They landed on the fantail of the ship and were in the operating room within a very short period of time. I was in a city in the Delta during the Tet Offensive when we were overrun and I was taking care of wounded American military people, including a Colonel who had been shot in the neck and in the head. I took him by heliocopter about fifteen miles into a field hospital and within fifteen minutes after he was there he was under the anesthesia. Although this man had a perforation of his external carotid artery, everything went so smoothly that the man was back in action within three weeks after the surgery had been performed. With all the heliocopters we have built and the pilots we have trained for Vietnam, I am wondering why we couldn't get some of the "surplus" and develop an air transport program for Montana for getting seriously ill and badly wounded patients into medical care facilities where the facilities and the physicians are available to provide immediate care.

Dr. Pratt: Thank you very much, John. Your presentation showed a broad perspective and included many aspects of health care delivery besides those that face the practicing physician from day to day. We are very fortunate to have people like John in Montana.

Our next participant on the panel is Mr. Fred K. Holbrook, Administrator, Montana Deaconess Hospital of Great Falls who will talk about existing health care facilities in Montana.

Fred K. Holbrook: I, too, am very pleased to participate in a conference of this type where we have brought together a broad representation of citizens in our state to take a hard look at our health care system in Montana. I enjoyed the opportunity of working with the planning committee and Prof. Uphoff in arranging for this conference. The attendance here speaks well for the interest of our people in health care. I assume you are here to take a hard look at our activities and see what we can do. We really can't achieve improvements and higher levels of success without assessing our status periodically and then establishing goals and priorities. I really feel that the success of this conference could have far-reaching effects for Montana in years to come and I sincerely hope that it will be a success. Perhaps, an involvement of consumers, providers, etc., in planning for better health care can achieve a success similar to that of the obstetrician. They say he really can't miss being successful because "he has so many men working for him". I think the real success of this conference is going to emerge from the discussion groups in which we will sit down and forge some new concepts for better health care delivery in the state. As an administrator involved in running a hospital, let me give you a few basic facts about our state.

Montana is the 4th largest state in the United States, it ranks forty-second in the nation in population with about 740,000 people. Our population is increasing about one percent per year as compared with the national average of about 1.9 percent per year. Ten percent of our population are over the age of 65, as compared to the national average of 9.2 percent. In other words, we have a slightly larger percentage over 65. Four percent of our population are Indians. We have an average of five persons per square mile as compared with the national average of fifty-five persons per square mile. Only the states of Alaska, Nevada, and Wyoming have a lower population density than we have. About half of our population is rural and half is urban. For the nation as a whole, only about 30% is rural. We are just beginning to become aware of the problems that urbanization brings with it. It is estimated that 26% of the population live more than ten miles from a general hospital. Half of these people must travel over 25 miles and a fourth must travel between 50 and 100 miles in order to reach the nearest hospital. This gives you some idea of the impact that distance has on the economic, the manpower and the facilities problems of providing health care throughout the state. Except for the population concentrations in half a dozen cities in the state, we are sparsely populated, there are great distances, we are not developing very rapidly, and our health care system is developing around these factors.

Now let's look at the health care system just a bit. Generally, the physician is the primary focus of the medical care system and the hospital is the central facility for the services in the system. Here is a bit of information about the status of manpower and health care facilities in Montana. We have about 103 physicians per 100,000 population as compared to the national average of 145 physicians per 100,000 population so we are below the national average. Only about 38% of our physicians are located in the rural areas. We actually have six counties in the state without any physician right now. And these six counties have a population of about 11,000 persons.

Montana has about 350 Registered Nurses per 100,000 population as compared with the national average of 298 per 100,000, so we have more nurses than the national average. There are 54 dentists per 100,000 population in Montana as compared with the national average of 53 dentists per 100,000 population, we're about "even Steven" there. However, when we look at the paramedical field, those referred to as the "health professionals", we find that Montana is well below the national average. We are in very short supply of these special fields. In my judgement this is related to our small hospital system - a system which has difficulty attracting and paying for adequate levels of health workers. And when we do need additional personnel,we must generally go outside the state to get them. I would say we need more medical programs and facilities to attract more physicians and allied medical personnel where we have a shortage. This is my personal feeling. People don't migrate to "nothing", they migrate to "something".

Montana has sixty-two community general hospitals with a total of 3,510 beds. Among these there is only one proprietary hospital. We also have three U. S. Public Health Service Indian hospitals, three Veterans Administration hospitals and three State hospitals. There are no hospitals in four of our counties. Twenty-two of the community hospitals are accredited with joint accreditation of hospitals as are five federal and one state hospital. Thus, you can see that over half of our hospitals are not accredited by the Joint Commission of Hospital Accreditation. Forty-five of our sixty-two hospitals have less than 58 beds. When you consider the fact that middle-sized and large hospitals generally start at about 200 bed-size, you can see that most of our hospitals are small. Sixty-five percent of our hospitals are small hospitals and 31% of the hospital beds in the state are in those small hospitals. This is important to keep in mind as we analyze our health care system in Montana. The average hospital occupancy rate is approximately 65%, which is below the national average. I am sure this is related to the location of our population and the location of our hospitals. Our lower utilization is related to our small hospital system which was, in turn, influenced by the Hill-Burton thrust with its emphasis on helping to build hospitals in many communities that asked for help. We have somewhat more hospital beds per 1,000 population than the national average. I am sure that this is related to the fact that we have large rural areas and great distances. The general hospital admission rate is 164 per 1,000 population, compared to the national average of 136 per 1,000. I, frankly, think we admit more people to the hospitals than the national average because we are largely a rural state and people wait to the last moment to get medical attention and frequently they wait too long and then the hospital utilization rate goes up. The state, as a whole, does not have an extensive county system such as you find in other areas to provide for the medically indigent population. Silver Bow General Hospital in Butte, the largest county general hospital, and only seven other county hospitals are the only county hospitals in the entire state. These county hospitals are generally located in communities where there are no other hospitals and, in a sense, they become community hospitals. When we look at how Montana looks after its indigent we find that it has neither a city nor a county system. This, therefore,

places a heavier burden on the voluntary hospital system and as it relates to the programs for the disadvantaged population. It also affects the Indian living off the reservation. There are really very few state or county hospital clinics which are readily available for the poor, be they white or Indian.

Many of our hospitals need modernization, some need replacement. A 20 or 25 year old hospital can easily be out-moded and should either be completely modernized or replaced. We have many that fall in this category. Because of our small hospital system, this need may not be quite as apparent to us because we don't have the sophisticated medical equipment needs for facilities that the larger hospital systems have. You will recall that I indicated that 10% of our population is over 65 years of age compared to the national average of 9.2%. Therefore, our needs for long-term care facilities may be slightly greater than the national average. We have 67 extended care facilities and nursing homes in Montana with 2,800 beds. The average size of these facilities is 42 beds. The average size in the nation is 50 beds. The average occupancy in our nursing homes in Montana is 90% which means our utilization rate is high, the average length of stay is 250 days. Only 6 of the 67 facilities are accredited by the Joint Commission. We also have 44 institutions in the state with about 1200 beds that provide "personal care homes" and we have 28 licensed boarding homes. These have a quasi-relationship to the medical care system in Montana.

When we look at the way physicians practice we find that most physicians are in solo practice. Group practice and clinics are generally found in our urban areas and this, once again, relates to our rural nature of our state. Because of the great distances in Montana it makes a prepaid group practice program difficult to organize. Such could be developed in the urban parts of the state or, perhaps, could better work if developed in the state as a whole, if the system were tied together. Now let us take a brief look at the transportation system for health care in Montana. We have 75 ambulance operators and there are 100 vehicles. Three are operated by hospitals, 22 by Fire Departments and 18 by funeral homes so you can see how fragmented our system is. The remainder are privately owned and operated. Each unit serves an average of 2,100 square miles. There is one heliocopter on call and there is really very little inter-connection between the various parts of our so-called "system" of ambulance care. There is really no system. In view of our "small hospital" system in the state and the large distances between facilities a good ambulance system is very important but it must be said that today we have a very inadequate system. There is no overall coordination between primary and secondary centers and availability is poor. And yet, looking at whatever is done in the rural system, transportation is a very important element.

Let me give you some of my own conclusions that might be explored further in the discussion groups. This may help you to develop conclusions and projections about where we might go from here. Because of the rural nature of our state we have developed a "small hospital" system without any formal structure of primary and secondary relationships, e.g. satellite hospital relationships with the larger hospitals. Each hospital stands independent unto itself.

Though the small hospitals are important to the general and emergency needs of the small community, we have not tied the small hospitals together into a true state hospital medical care facility system. There may be specific areas where the situation is different, but, generally, this is the case. I am glad to see a development of state and area-wide comprehensive planning both in the nation and in the state. I would hope that our planners will not be content to just sit back as a control board to approve facility requests and to approve or disapprove programs. Our planning should be more involved with positive rather than negative programming. The primary thrust and objective should be the organizing of coalitions and the coordination of what we are doing. This should encompass management as well as facilities. As it is now, Montana Deaconess Hospital can not go to a small hospital and say, "Can we help in any way either with your facilities or management problems?". The local pride in the community is going to say, "Who's this big hospital trying to take us over?", and, therefore, nothing happens. I would hope that Comprehensive Health Planning can help implement the concept of developing a system that ties our hospitals together in a meaningful health care delivery system. This could be one of the primary roles of Comprehensive Health Planning.

Although it is understandable that each small hospital should want to have as much special equipment as possible, I personally feel that continually staffing these services with properly trained medical personnel will continue to be a growing problem and will not get better. I do think the Regional Medical Program has done an outstanding job of training not just nurses in coronary care units, but also other allied professional groups. Nevertheless, I think that the need for more trained persons in these areas will continue to be a problem. We should endeavor to have more ties between existing facilities rather than developing independent units. We must place more emphasis on primary centers in the state as a big step towards giving us an improved health care delivery system. We do have well-trained personnel and some good facilities but our delivery system needs to be coordinated. Unless we do this we are not going to see the best use made of our manpower and facilities. There is need for more programming of the medical services available in our state. Due to the cost of staffing, emphasis should be placed on primary centers and these should be tied to our small hospital systems. If we don't do that we are going to continue to send persons to Portland, Oregon and to Minnesota for specialized treatment. We are geared to the small hospital system and we have not placed enough emphasis on developing various specialty care programs so that we can provide care on a more total spectrum of health care delivery within the state. We also need to expand the primary health clinics and to develop transportation methods to get the poor to the health centers. I don't think it is realistic to expect that all people will want to travel to where specialty care is available. For some, we will have to go the other route and rely more on mobile clinics and neighborhood clinics for the poor and rural citizens. These should, however, be tied to primary centers in order to make the newer and more sophisticated medical centers available to rural areas and meet the general needs of the people. I would hope that this could be our thrust so that we can provide high quality and comprehensive care to all the people of Montana.

Dr. Pratt: Thank you, Fred, for your fine statement. You presented conclusions and helpful suggestions for the future. We will now hear from the final panelist, Mr. Jack Carlson on "How is Health Care Paid for in Montana". Mr. Carlson is Director of the Division for Medical Assistance, Montana Department of Public Welfare.

Jack Carlson: My assignment is to discuss how health care is paid for in Montana. First, let me give you an overview. About $100,000,000 was spent on health care in Montana during the calendar year 1969 and this does not include about $30 million spent on Public Health, for the Public Health Department and the Board of Institutions nor does it include the amounts spent by private philanthropic associations such as Muscular Dystrophy, the Cancer Association, the Red Cross and others. Private insurance and private individuals, together, paid about $57,900,000 for health care costs in the state. Blue Cross and Blue Shield and the insurance companies paid about $32,000,000 and individuals paid another $25,000,000 in "out-of-pocket" expenses. Government agencies paid a total of $43,338,000 for Medicare, Medicaid, etc., in Montana in 1969. Of that amount, $21,015,000 was spent for people 65 years of age and over. The next major provider of health care is the Medicaid program which provides services to the medically indigent in the state of Montana and limits services to those categorically related to welfare. The total amount spent on this program in 1969 was $8,696,000. In addition to this amount, county welfare departments spent another $3,200,000. The third largest provider of health services in the state is the Office of Public Health and the Bureau of Indian Health Services. They spent $5,800,000 on health care for the Indians, primarily those on the reservations. The fourth major health care provider in the state of Montana was the Veterans' Administration which spent about $2,900,000 for veterans. Industrial accident insurance covered another $1,300,000 in health care costs and military defense spent $2,298,000 in Montana on health benefits for military personnel and their families. In addition, there were expenditures for the Public Health Department and other minor programs such as the Children and Youth Project here in Helena.

Now that I have given you the gross statistics on costs, I would like to comment on some of the inadequacies of the health programs in Montana, as I see them. We must remember that Medicare and Medicaid are the two major sources of funds in the government health programs in Montana. Actually, they are not health programs per se nor designed as health programs per se. They resulted from political compromises in the United States Congress. Anyone who thinks that there is much similarity between adequate health programs and legislation resulting from political compromise has something to learn about politics. What I am trying to say is that any major legislation usually reflects a compromise between the major vested interests and the politicians. The federal government in order to appease the states had to design a program with certain flexibilities that allow the states certain options in the exercise of their responsibilities. It is important to keep in mind the philosophy and motivation of those who design a health care program. We should not forget that private insurance companies are profit oriented. By their very nature they must be interested in profit to survive. When we talk about a national health

care program this factor must be kept in mind. At the present time, the major portion of health care in Montana is still being provided by the private sector. We should ask ourselves if our philosophy in the state of Montana allows us to make money on the sick. This is something I must keep in mind when determining wage rates for proprietary and non-proprietary institutions. Fortunately, I have no problem in relation to the hospitals. We have only one proprietary hospital, but when it comes to nursing homes, there are 16 government facilities, 9 church-run facilities and the rest are proprietary facilities. There is a real difference in the cost of care if you are going to allow for a profit in the provision of care. From the statistics Mr. Holbrook gave you about hospitals, institutions and physicians in the state, you can see that we have a "hodge-podge" with no organizational structure. This is certainly not conducive to an economical system.

When you speak about the 2,000 miles for coverage for ambulance services, I would like to give you a statistic published by the Safety Department of the State of Montana on ambulance service. That department points out that on the average it is two hours before a wounded soldier in Vietnam reaches a medical facility for treatment while in the state of Montana, the average time for getting to a medical facility after an auto collision is six hours. We must consider the possibility of a more adequate organizational structure for providing medical services. We also have to strive for greater utilization of the beds in our hospitals and nursing homes in order to bring the units costs down. The nursing homes in our state are only 80% occupied. How can you make an economical unit out of a ten-bed nursing home which has to have three nurses in order to provide 24-hour nursing care? All the computers in the world are not going to be able to figure out how to make that into an economical unit. These are the kinds of problems that we have to be concerned about when designing a health system for Montana. It seems to me that more emphasis should be placed on developing a coordinated and integrated health care system for everyone - one that does not put up barriers between Indian Hospitals, Hospitals for Veterans, etc. What we should develop are genuine community health facilities to serve all our people regardless of age, economic status, ethnic backround or military service.

THE NATION'S GROWING CONCERN ABOUT HEALTH

Chairman: Lt. Governor Thomas Judge

Speaker: Hon. John Melcher, Congressman,
Eastern Montana District

Lt. Governor Thomas Judge: This morning I had the opportunity to welcome you to this conference and now I have the opportunity to introduce our Congressman from Eastern Montana. John Melcher came to the Legislature at the same time I did in 1960 and it wasn't long before the members of the House of Representatives, on both sides of the aisle, recognized that John had tremendous ability and dedication. He served in our House of Representatives with distinction in 1960. In 1963 he moved to the State Senate and in 1969 he again served as a state representative. As you all know, John was elected Congressman from Eastern Montana ten months ago. In those ten months John as done an outstanding job of introducing and supporting legislation in Congress. As a legislator and as a congressman he has always been concerned about health. His record in the state legislature was outstanding,especially in his strong support of legislation for medical assistance, for mental health facilities, etc. He is currently involved in a congressional study of meat inspection. I think you will agree that his experience in veterinary practice should be of help in this important area of health. John is also a member of a study group on enviornment that is particularly concerned about pulmonary emphysema, a problem of special concern to those of us in Western Montana. So, it is with a great deal of pride that I present to you John Melcher, Congressman from Eastern Montana.

Congressman John Melcher: Thank you, Lieutenant Governor, Tom. A recent report on the 16-county area of Eastern Montana emphasized what some of us in Montana have known for a long time--that if we want to develop better health care systems, to have more hospitals, to have more nursing homes and more facilities to take care of the health of our people, we have to have a better economy, too. I am glad that the report does emphasize these economic facts of life. If we want to make progress, we must have a growing and developing economy rather than one of out-migration and a dwindling economy in order to do some of the things we would like to do in health care. To move toward better health care, we must all work together at the local, state and national levels. Let me assure you that I support the resolution adopted by the Montana Hospital Association which asks the Social Security Department to recognize that hospitals in rural areas should have different types of regulations than city hospitals. This is one area where those of us in Congress from states like Montana, must continually explain what is involved out here--the meaning of vast areas and sparse population.

One of the important problems facing this country is the problem of drug abuse and drug addiction. This problem is widespread and if we are going to deal effectively with it, we must understand the extent of

the problem and what causes it. This drug problem is no longer limited to isolated groups in our society but touches virtually all segments including some of our own families or friends. I am pleased that several steps have been taken by Congress on the drug problem to date. The National Clearinghouse for Drug Abuse Information has released information and offers some hope as a start towards educating the public about just what is involved in drug abuse. A national educational effort is being undertaken and one of the courses on the problem of drugs, prepared by Great Falls, Montana educators, has just been selected as one of ten from around the country to serve as illustrations of how schools are preparing their own educational programs. These programs must then be extended to the entire community. This is a very small program right now as measured by other federal programs. An announcement from the Department of Health, Education and Welfare reports that President Nixon has named a 26-member National Action Committee to administer a $3.5 million teacher-training program in drug education. The training will start this summer. Grants to the states will range from $40,000 to $210,000 depending on their populations. But to be successful, this program must be broadened to reach the entire community. This is such a serious problem that every druggist, every physician, every parent, every public-spirited individual, every nurse and every hospital worker has to become informed about the cause and treatment of drug abuse. Another program has been proposed which calls for $29 million in funds to extend this educational program on drugs to the communities and school districts.

Still another health problem I am concerned about is seeing to it that there are adequate funds for the construction and renovation of our long-term care facilities for the elderly. We need at least $3.5 million for this purpose in Montana, right now. We have over 4500 care beds at the 110 facilities in our state. Although we have 4500 beds for nursing home and extended care we have about 23,000 persons in Montana who are over 75 years of age now and I presume that number will increase. The need for doing more for Montana's elderly in our nursing homes is evident to anyone who visits his relatives or friends there. They should not be relegated to wearing only their pajamas or nightgowns or bathrobes but should be encouraged to have a continuing interest in life. Exercise and physical therapy should be made a part of their daily routine and everything possible should be done to provide enjoyment in their declining years. I cannot tell you that we have done enough to solve the problem of how we are going to get the funds to finance Hill-Burton programs or, having gotten the funds, how we are going to get them unfrozen so they can be used. We have been in the habit of getting $200,000 to $250,000 per year in Hill-Burton funds and I think it is vital that we continue with that program.

We must seek to improve and enhance programs of health care at all levels. The question of national priorities and where are we going to spend the money from the Treasury is one that must be decided by Congress. We must also be concerned about how to control inflation. But when it comes to setting the values, to establishing priorities, this is the responsibility of Congress. I think the President's policy of withdrawal and Vietnamization of the war in South Vietnam is correct.

I also support the President's program on crime control and his new and innovative ideas on welfare reform, but I do not believe that anyone should inject the cost of health care as a factor in the argument over inflation. No matter how deep the advisors are around the President, and how demanding the Bureau of the Budget is, there is absolutely no excuse for curtailing health programs or for curtailing valuable and needed research in health matters.

I am indebted to Dr. M.L. Hendley in Orlando, Florida for sending me some interesting information on cancer. He is heading up a national drive to restore funds for cancer research. According to his figures, 59,600 persons died from auto accidents last year while 323,000 people died of cancer. He points out that during the worst polio epidemic in 1952, about 3,300 people died as compared with almost a hundred times that many who succumb to cancer each year. He then gives the share of the national budget each of us (on the average) spend for various national programs. For each man, woman and child in America we spend $410.00 for national defense and $125.00 for the Vietnam war per year. We spend $19.50 per person for space research; $19.00 for foreign aid; and $7.00 for the National Institute of Health of which $0.89 is spent on cancer research. With such a high priority for military expenditures and such a low priority for cancer research, is it any wonder that our national goals are being questioned? The administration is again asking Congress to balance the budget but most of the cuts are to come on domestic programs such as health-related research.

I spoke about a constitutional mandate for the Congress. It should be our job to spell out priorities, values and needs for our country. Well, our greatest needs are not in South Vietnam. We may not be able to withdraw as quickly as you and I would like. We may not be able to curtail military spending as fast as we would like, but I believe we can curtail it quickly enough this year to assure that those programs for health research and for health care can be funded as they should be. It is a constitutional mandate for Congress to make those determinations. It is part of our legislative history that the original decisions are made in the House of Representatives since that body originates legislation on appropriations and it is up to each of us serving there to use our best judgement. I intend to vote for more funds for health care and for research in health matters. I think it my duty to do so.

Dr. Pratt: Thank you, Congressman Melcher. We are delighted to have you at the conference. The people who are here come from all walks of life in the state of Montana. We also have people from the states of Washington, Utah, Colorado, Minnesota, Wyoming and Idaho. They all have one common interest and that is better health and better health care, not only in the development of better health care delivery systems, but also in doing all that can be done to conquer the health problems that plague us. We are encouraged to know that we have a man in Washington who is definitely concerned about health and committed to do something about it.

A "MODEL" PROPOSAL FOR MONTANA

by

Walter H. Uphoff

Professor of Economics, University of Colorado
HEW Project Director

Dr. Pratt: The next speaker has been directly involved in the planning and promotion of this conference. He met with representatives of various provider, consumer and insurer interests last September to discuss what he and his staff could provide for Montana if we were interested in scheduling a conference on health care delivery systems. There was substantial agreement that a conference dealing with health care costs, distribution of manpower and facilities and health care delivery systems would be worthwhile and this conference was scheduled. A program planning committee was designated at that time to work with Professor Uphoff in working out details for topics and speakers. One of Mr. Uphoff's assignments under his contract with HEW is to develop a "model" proposal for health care delivery on a state-wide basis. Today he is going to share with us some of his thoughts about what might be done in Montana if enough people from a broad enough spectrum of consumers, providers and insurers can find enough common ground to develop a program.

It was a conference on Prepaid Group Practice Plans, held in Denver, Colorado in March 1968, under the direction of Mr. Uphoff, that led to a contract between HEW and the University of Colorado for scheduling educational conferences on health care delivery in the states of Region VIII. One such conference was recently held in Utah and I understand the next one will be held in North Dakota early in May.

This conference, then, is one of a series made possible under a Public Health Service grant to pursue the ideas that we have started to develop and, I understand, to eventually seek some solutions to the problems which have been posed by previous speakers. One suggested approach is the "model" which Mr. Uphoff has developed:

Walter Uphoff: I am glad to have had a part in planning for this conference and I want to say that I greatly appreciated the enthusiastic and cooperative attitude of the Montana committee members (listed on your program) who played such an active role in planning this conference. I want to express my special thanks to Dr. Pratt, chairman of the planning committee, and to Bob Johnson from the Montana Office of Comprehensive Health Planning for their cooperation on invitations, arrangements, etc., which helped greatly in making this a successful conference. I am also glad to see such a large and representative number in attendance.

My comments this afternoon will, I hope, provide an added stimulus for the discussion groups this afternoon and enough questions for tomorrow morning so that we might wind up on a note of enthusiasm and determination

to do something about the health care problems in the state. Montana may not have more problems than other states, but it is generally recognized that all states have problems in health these days--on costs, availability of care, etc. I would like to start by saying that even though our contract calls for developing a "model" proposal for health care delivery, I hasten to add that we have neither the authority nor the responsibility to say which "road" you should travel in developing your health care programs. That decision is up to you. We can merely serve as catalysts--pulling together some of the basic information about the status of health care today and arranging for some speakers to share their thoughts with you.

No one person can rightly claim that he has a complete answer to the health problems of a community, state or nation and I am sure that the "model" I have prepared could be improved with your help. The "model" I want to discuss with you takes into account the fact that in much of HEW Region VIII, including Montana, we have large expanses of territory with not very many people and a limited economic or tax base. With this in mind, I did prepare a proposal, which at this time I have called an "intermediate draft" because I hope to get further comments and suggestions from you and those at other state conferences before I prepare a final draft.

In the time I have on this program I can merely give you the main points in the forty-page proposal I prepared for HEW. I hope that what I say will not be too much out of context and that I can convey to you a picture of how I think a health care delivery system might be developed in this state.

Numerous articles have appeared in recent months in such magazines as Fortune, Business Week, The New Republic, and in the daily press, all calling attention to the "crisis" in health care costs and in health care delivery. Some of the changes proposed or anticipated are viewed as a hope by some and as a threat by others. What kinds of programs are finally developed depends on the compromises and accommodations which are finally reached among groups with conflicting interests or among groups that have at least somewhat different goals and objectives. No program will ever satisfy everyone. Any program which is adopted must take into account the legitimate interests and concerns of all groups that have a role or a concern in the health field, be they consumers, providers or insurers.

I have started with the assumption that something could be done at the state level, quite independent of what does, or does not, happen with regard to some form of national health insurance. If some national program is adopted at a later date, whatever viable program is in operation at the state level could be integrated with a national program and could also have some influence or impact on the form a national program takes.

What I have done is to draft a proposal that could be adopted by a state legislature and implemented on a state-wide basis. When we think of health care delivery we can think of (1) the indemnity insurance

approach which is used by many people today, (2) the voluntary prepaid group practice approach and (3) we can also think of a legislative approach. The contract we have with HEW calls for incorporating the concept of prepaid group practice as a part of a health care delivery system--where it is feasible and where enough consumers and providers of health care chose that form of a delivery system.

When I moved from Minneapolis, Minnesota to Colorado in 1963, I left behind a very good prepaid group practice program. In fact I had been a charter member and later president of the board of directors of the Group Health Plan there, so I have had some occasion to see this type of program function both as a consumer of health care and as a member of the governing body. I recognize that the type of prepaid group practice program which is successfully serving the health needs of 27 or 28 thousand persons in the Twin Cities area cannot be adapted to every situation in Montana or any other state.

What I am suggesting in the "model" is that you start with as many of the existing institutions, agencies and organizations as possible. You have to start where people are, not where you would like to have them. There's an old saying, "You can't take someone from where he ain't to where he don't want to go." It is much easier to start where people are and build on to existing programs. One thing that is certainly needed is more communication between health agencies and, of course, more coordination and cooperation. You can't expect to have efficiency and economy in health care when you have separate programs for veterans, Indians, welfare, mental health, etc. What makes more sense is one health care system regardless of the color of your skin, your age, the church you belong to, the amount of money in your pocket-book, etc. Health should be a public concern just as education has been for years.

It is often said that we pay for a good education whether we get it or not--meaning thereby that if we try to skimp on direct expenditures with crowded classrooms, low teacher salaries, etc., society pays indirectly in terms of less well-trained citizens, greater crime and delinquency rates, lower employability and so on. That same concept can also be applied in the health field. If we don't provide adequate health care for everyone, we pay indirectly as a society through more absenteeism from the job due to illness, lower productivity, more communicable diseases, etc.

What I have proposed is that a state might enact legislation which would give the existing Office of Comprehensive Health Planning more authority, more responsibility, more budget and more staff to develop and promote a coordinated program of health care. I am suggesting, for instance, that this program not be confined to the civil service restrictions which have crept into the programs of practically every state and make it virtually impossible to obtain the competent staff needed for the success of such programs. Special skills are required in developing new health care programs. Skilled manpower is in short supply. If the salaries that can be paid are too low this will be "false economy" and the first handicap for any new health care program.

The Director of Comprehensive Health Planning would be responsible for the overall planning and coordination of health care programs in the state. A Deputy Director should be hired, with practical experience in the prepaid group practice field, with more specific responsibilities for developing new programs in health care delivery. If a proposal such as I am going to outline, or any adaptation thereof, were enacted by your legislature, some provision would have to be embodied in the legislation for providing the revenues needed to implement the program. The money must come from somewhere. It might be raised by general taxation or a payroll deduction tax. I am suggesting instead that the funds be raised by a tax on health insurance premiums. The deputy director of the new CHP, with more authority and responsibility, would communicate with Blue Cross and Blue Shield and all licensed insurance companies in the state that sell health insurance and explain the terms of the legislation which I am suggesting might be enacted (assuming that such legislation were, in fact, enacted). He would state in effect: "As a means of dealing with the problem of devising an economical and efficient health care delivery system that preserves the greatest amount of freedom of choice consistent with the goals of efficiency and economy, a law has been enacted which gives insurance carriers the option of either (1) paying a 3 percent tax on premiums and providing a dual choice clause in their policies--so that those persons who want to avail themselves of health care through a group practice prepaid system, where available, can do so (or, when there is enough support among consumers and physicians to warrant it, starting such a program), or (2) paying a 5 percent tax on premiums if they do not provide such an option." The reason a higher tax is proposed for companies not offering a dual choice is that under such circumstances it would be more difficult for CHP to extend health care where it is needed most. The tax would be collected by CHP but turned over, in toto, to existing group practice clinics in the larger communities with whom arrangements had been worked out for meeting the health care needs on a prepaid group practice basis for persons interested in that type of care.

The deputy director and/or his staff would meet with persons interested in health care delivery at the community level and encourage the formation of Community Health Councils. These councils, in consultation with CHP, would then decide what to do to develop better and more adequate health care for their communities. Just as the one-room schoolhouse has given way to a consolidated school system in most parts of the country, I am suggesting that the consolidation of health care services be encouraged on a voluntary basis. I am further suggesting that if, within a 25-mile radius or so (perhaps it would have to be 35-40 miles in some cases to find that many persons), about 600 families could be identified who would provide an economic base for a health center or a health team, the insurance premiums they would pay would be sufficient to support two physicians, five nurses, a medical secretary, a laboratory technologist and perhaps a medical social worker; and there would still be enough funds left over to pay the cost of specialist care at one of the larger clinics, and hospital care when needed. These health centers in the less densely settled areas would be considered the satellites of the larger clinics which provided a prepayment alternative, and arrangements could be made for periodic visits of specialists from the major

clinics to these health centers--with extra compensation, of course. Where mutually satisfactory arrangements could be worked out, the physicians from the health centers could also do some work in the major clinics from time to time. If there were more than 600 families within the natural trade area of a health center, it would provide the income for more staff and for a larger proportion of the health needs being met in the community.

One of the serious problems in many rural communities is getting and keeping physicians. This is usually not because they cannot make a good living there but because smaller communities usually do not provide the same cultural advantages and educational opportunities for the physician's children and the pressures build up to move to a larger town. I believe that an efficient and growing satellite (or health center) would be a step in the direction of creating the environment in which it would at least be less difficult to recruit health personnel.

Persons who favor prepaid group practice medical care want high quality care and are willing to pay for it. It should be obvious that unless the net income of physicians in prepaid group practice programs is comparable to the net income of physicians in solo practice or in group practice, there will be no great move in this direction. In the final analysis the income and working conditions must be such as to attract good staff if the program is to succeed. I doubt whether there are so many physicians who are ideologically committed to any one system of payment for services performed that it would be difficult to establish some voluntary programs which paid physicians primarily on a salary basis--with possible additional income in the form of a bonus for work well done--or part of the income from supplemental fee-for-service care.

I am not for cheap care. I am for efficient and coordinated care that does not over-utilize or under-utilize manpower and facilities. The premiums from persons who chose prepaid group practice care--either from a clinic that had agreed to provide such care in a large community, such as Billings, Great Falls, Missoula, Helena, Butte, etc. if they lived within the service area of such a clinic, or from one of the community health centers or satellites I have described--would be paid to the larger clinics in return for their agreement to provide specified direct services without all the expense of individual billing for each procedure. The premium monies for members of the health centers I have described would also go to the major clinics which are closest to these centers; and an administrator of the prepaid part of the group practice clinic's services would work with the health centers and allocate the necessary part of the funds to pay the salaries of the satellite staff. These minimum health teams (with larger teams possible where more people join such a program within a trade area) could provide perhaps 60 to 70 percent of all health care. The staff would be on a salary and would not lose income when referring patients to specialists in the larger clinics or to the hospitals in the larger cities, when deemed advisable.

With the amount of specialization that has occurred in the health field in recent years, it is unrealistic to expect that every community can have access to the entire spectrum of specialization--unless a system is developed that ties local health centers in with specialty clinics. And even specialty clinics should be free to refer special problem cases to places like the Mayo Clinic or university hospitals.

Although it would be simpler to have a series of salary schedules for paying physicians who work in the major clinics where some of the clientel become members and are entitled to direct service care when needed, I am not saying that this is the only way of compensating physicians. I might mention that last summer I visited a large physician-owned and operated group practice clinic with about 90 physicians which had switched in 1953 to a five-step salary as a basis for payment rather than determining their income on the basis of work performed, years of service and new "business" brought to the clinic. I understand that this clinic is now considering a program of prepaid care for low-income persons surrounding that community. A Blue Cross program is working with this hospital in developing the prepaid concept. This is a departure from the traditional approach, but it is obvious that we are not living in a static situation and that changes are coming and will continue to come.

There is much more discussion and dialog today among physicians, hospital administrators and health insurance leaders on new approaches to health care delivery, than there was several years ago. The so-called "model" I am suggesting envisages a program that would start where the needs are the greatest and where new approaches to health care delivery systems have greatest support among consumers and providers. In very sparsely settled areas it might not even be possible to enlist the support of 600 families as I have suggested and you might have to settle for one nurse or medical social worker as the first point of contact. Eventually, however, it should be possible to organize health centers or satellites in most parts of the state which would be affiliated with a larger prepaid group practice clinic in one of a number of larger cities so that you would have a network of communication and referral for providing better health care.

An integrated health care system should have coordination (and wherever possible a single administrative mechanism) for handling the out-patient care in clinics, the acute care in hospitals, the extended care after the acute phase is over, the nursing home care for persons who need this kind of service, and home care where indicated. All of these should be part of a total health care system. And we should also keep in mind that dental care, psychiatric care, etc., which are usually excluded from conventional insurance programs, are paid for somehow and might better be incorporated in a program of comprehensive care.

Another feature I have incorporated in my proposal is a grievance committee for consumers--a committee that would hear complaints, try to ascertain whether or not there is some basis for the complaint or whether it is a misunderstanding, and then try to help resolve the

problems--to the end that better care is provided and that the consumers have a mechanism for airing their complaints. I am not saying that the consumer is always right, but "what a person believes is reality to him, no matter how far it may be from the facts." With this in mind a grievance committee could play a role in bridging the gap which often exists between the providers and users of medical services. I suggest that at the state level someone be designated within the CHP agency as chairman of a grievance committee that could also determine to what extent adequate and proper health care is being provided under the indemnity insurance programs.

Since some people live much farther away from health facilities than others I am suggesting a program of partially equalizing the burden of travel by providing "travel credits" so that instead of waiting for the ambulance or hearse to come the family is encouraged to take the patient to the clinic at an earlier stage. If the family lived 15 miles or more from a clinic or health center, it would get 5 cents per mile credit up to 25 miles and 10 cents per mile beyond that for every trip made for health care--payable once a year or whenever the credit amounted to $25.00.

Persons who are on welfare or who are medically indigent should be integrated into whatever health care system is developed in the community rather than treated by one fragment of the system. In developing a program for health care for those on welfare and Medicaid, CHP could determine average costs per family paid for health care the previous year and then develop a basic program of rates and benefits and invite Blue Cross and Blue Shield and insurance companies to bid for providing health care for all those eligible for help in the state. Whatever carrier came up with the bid with the most comprehensive coverage (for an established premium of, say, $35.00 per month) would get the contract for the following year. Those covered would also have freedom of choice. They could elect to get care through a prepaid group practice program where available and/or through one of the health centers referred to--or they could seek health care outside this system if they were prepared to pay any differences in cost, so that the cost to the taxpayer would be the same.

The "model" I have proposed for health care delivery at the state level would also concentrate on developing an adequate ambulance system and the necessary communication system to go along with it to implement better emergency health care. A directory listing health personnel and facilities should also be prepared and made available to everyone who would have occasion to use it. Such a directory should contain names and addresses of physicians and other health personnel, what they are best qualified to do, how, when and where they can be reached, etc. In many communities a central answering service could be supported to get in touch with the most appropriate person available to provide needed care.

The "model" I have prepared contains many other details. If there is enough interest in and concern for better health care among a substantial part of your citizenry--consumer, provider and insurer--you should be able to modify or adapt what I have suggested, to meet your needs, draft it in legislative form, and try the legislative route to give each Montana family a choice between the two basic approaches I have outlined. I'll be glad to consult with any groups or committees that may be established, but the decisions must be yours.

THE "PROS AND CONS" OF NATIONAL HEALTH INSURANCE

Chairman: John S. Anderson, M.D.
Executive Director, Montana State Health Department

Speakers: Max W. Fine
Drew M. Peterson, M.D.

John S. Anderson, M.D.: Interest in holding a Montana conference on health care systems was generated by Professor Walter Uphoff of the University of Colorado, working on an HEW project on health care delivery. He contacted people in various communities of the state and found enough interest to schedule a planning session in the State Capitol last fall. Dr. Sidney Pratt, Director of the Montana Regional Medical Program,was designated as chairman of a planning committee and together with representatives of other interest groups, this conference was planned. Dr. Pratt has done an outstanding job of providing the leadership for making this conference a reality. I want to thank him and Prof. Uphoff,as well as Robert Johnson of the Office of Comprehensive Health Planning, and the other members of the committee for their team effort.

The two speakers this evening are to discuss the "pros and cons" of National Health Insurance. It so happens that they represent two "goliaths" on the American scene--one the American Medical Association and the other the Committee for National Health Insurance which was spearheaded by Walter Reuther of the United Auto Workers. But, instead of a fight, I expect to hear a serious discussion of the differences in philosophy that exist between the spokesmen of these two organizations. We are privileged to hear two speakers who have had extensive experience in the health care field. Let me give you a brief backround on both speakers.

Mr. Max Fine, a journalist, worked for the International News Service at the United Nations. He did such a fine job there that Mr. Dag Hammerskold asked Mr. Fine to work for him. From there he went to work for commercial insurance companies and was in charge of providing economic information to the public. Then he went to Washington to spearhead the campaign for Medicare and worked for the Social Security Administration. He arranged for the first conference on health insurance for private insurance companies. After that, he worked for the Public Health Service in the field of medical care and then moved to Detroit to become Executive Secretary of the Committee of 100, now called the Committee for National Health Insurance with headquarters in Washington, D.C.

Dr. Drew Peterson is a practicing physician in Ogden, Utah. He is a specialist in internal medicine and a graduate of St. Louis University. He has been "where the action is", particularly the action in the American Medical Association. He has been a delegate to the AMA for the past 11 years. He has played a very active role in that organization, serving as chairman of the Committee on Community Health Care and as a member of the Council on Medical Service and the Committee on Health Care of the Poor. He is familiar with our Montana situation and also with the various proposals for providing health care to all the people of the United States.

THE CASE FOR NATIONAL HEALTH INSURANCE

by

Max W. Fine
Executive Director
Committee for National Health Insurance

It is a great privilege for me to be here and to share this platform with Dr. Petersen. Although I have never before been to Montana, I am familiar with its history of neighborliness and generosity, and having driven from Great Falls this afternoon, I now know something about its beauty.

The ruggedness of the terrain brought home to me the fact that, along with their independence and individualism, the pioneers who came to Montana had to develop a real spirit of cooperation. Otherwise, they could not have survived. And it strikes me that this particular conference reflects that same fine spirit of cooperation. This is a conference for consumers, providers and purchasers of health care--to examine the status of health care in Montana and to discuss what might be done to improve health care delivery for all the citizens of the state.

Everyone here is a partner in the conference. Too often since the enactment of Public Law 89-749, and even before that, I have attended health care conferences where consumer representatives were there only to warm the chairs. And it is very significant also that your conference deals with "systems." Now that both "planning" and "systems" have lost their unsavory qualities in the health field, we can look forward with some optimism to creative change. We need to utilize a systems approach to our health crisis and we need to plan for change on local, state, and regional levels. The replacement of our present nonsystem of health care involves not only new financing mechanisms, but it also requires additional manpower and new methods of health care delivery. And that means systems.

On the Committee for National Health Insurance, we believe that adequate health care is a matter of right and that only national health insurance can provide the leverage and support to restructure our health services toward fulfillment of that right. We do not come before you and say that we will deliver an adequate system of medical care for all. But we do say that you can do the job in your state and in your communities, under the right conditions and with determination and incentive.

America has the highest level of medical competence in the world, but for all our competence and wealth, there is a great gap today between what kind of health care can be provided, and the general level of care that many Americans get.

It is a sad commentary that, at the present time:

- We rank 14th among industrial nations in infant mortality; in 1953, we ranked 8th.

- In a very few years, we have moved downward from 13th to 18th place among nations in life expectancy for males; our death rate for middle-aged men is worse than anywhere in Western Europe and many other countries.

- In maternal mortality, we rank behind 11 other industrial countries.

- Within the U.S., the infant mortality rate of non-white babies is almost double the rate for white babies, and the non-white maternal mortality rate is more than three times the rate for white mothers.

Now I do not claim that the inaction of the health care professions alone is to blame for these appalling statistics. Certainly the individual has a responsibility to himself and to his family to eat the right foods, get the right kinds of exercise, forego smoking, etc. But equally certain is the fact that our health care system has not adapted itself to meet today's consumer needs and to apply the opportunities afforded by the current state of the medical arts. Preventive care is neither practiced nor sought. Our failure to diagnose certain diseases at an early stage is intolerable in terms of unnecessary illness and death. Rehabilitation services are inadequate in most parts of the country.

The central problem in the personal health care field, as we see it, is disorganization. Society, in our opinion, wants the health professions and the institutions to organize themselves and the system so that families can obtain comprehensive care, coordinating primary physician and specialist services, acute and chronic facilities, and preventive, diagnostic, curative and rehabilitative care.

But each year, it becomes more difficult for millions of Americans to find even the fragments of care they feel are acutely needed. We have excellent hospitals and outstanding practitioners, and a growing industry of ambulatory facilities, extended care facilities, intermediate care facilities, home health services, multiphasic screening businesses, and even health spas. But these are only pieces of comprehensive care, and they lie around unassembled. We need to free ourselves of the notion that we have already a health care system. We do not have a system. We have instead a wasteful, inefficient, ineffective, obsolete semi-functional non-system.

I would like to quote the first two paragraphs of a statement made last month:

> There is considerable evidence that the traditional concepts of health and health care are no longer appropriate.

> Rapid advances in technology and science, the development of increasingly complex equipment and procedures, the growing demands for more and better health services--all of these are substantially modifying yesterday's methods of providing medical care.

Now that statement was not made by Walter Reuther or George Meany. It was made by Governor Ronald Reagan in a health reorganization proposal to the California legislature.

In New York, Governor Rockefeller last week submitted his plan for a universal health insurance program in that state. And he described its objectives as follows: "The legislation I propose offers two interrelated programs. One would do much to clear away the financial barriers for individuals in need of basic health insurance protection. The other would bring into play the resources of the state in stimulating the development of a better system for delivering integrated and comprehensive medical care to people everywhere."

I might say just a word on Governor Rockefeller's first objective, that of providing people of New York with more adequate health insurance protection. According to the Health Insurance Institute, which is an arm of the commercial insurance industry, virtually everyone in New York State already has some form of health insurance protection. But in the Mountain States, fewer than three out of four have any health insurance.

It is Governor Rockefeller's second point that is the subject for tonight: stimulating the development of a better system. Unless we do improve the system, few of us--either as individuals or as states--will be able to absorb the increased costs of private health insurance premiums which will have doubled by 1975, according to an actuarial report prepared for the U.S. Civil Service Commission.

Now the problems in California and New York are not identical with those in Montana. But to many people in all three states and elsewhere, the health care crisis boils down to costs. Costs have been climbing rapidly. And insurance, even though a large majority of the population has some coverage, is still meeting only about one-third of the costs. On the Committee for National Health Insurance we do not share the narrow viewpoint that cost controls alone will solve our problems. We believe there is waste in the present lack of organization, and in the failure to structure the delivery system so as to provide health services in the most productive, economical, and efficient manner. But we believe that some of the best services are under-funded. Resources need to be strengthened, not weakened. Manpower gaps need to be filled, not measured again.

The manpower shortage, particularly the physician shortage, is a very serious problem. And even assuming we do all we can, we will still have a shortage of various types of physicians ten years from now. We need to develop new manpower to extend the arm of the physician, but without impairing the quality of service.

The unevenness of quality of services already is gaining increasing attention from crusaders ranging from Ralph Nader to the United States Chamber of Commerce, which isn't often accused of crusading, but which only last month set forth what it described as a "fifth consumer right," namely the right to quality and integrity in the marketplace, the very sector in which health care operates. Mr. Nader has indicated he will delve deeply into the lack of fulfillment of this right in the health field in the next few months.

The personal health care crisis in America, as we see it, involves at least four elements: (1) disorganization; (2) costs; (3) health manpower shortages, especially the shortage of physicians; and (4) unevenness of quality. There are cases of unnecessary surgery as well as unnecessary hospital admissions and often a longer stay than necessary if the person is covered by a hospital-oriented insurance policy.

Sixty years ago, Flexner called on medicine to face up to the four challenges of ignorance, incompetency, commercialism, and disease. Today, the major challenges in the personal health care field are disorganization, scarce manpower, costs and quality. If at least four major trouble areas compose what is called the health care crisis, it goes without saying that we can't end the crisis by solving one set of problems to the exclusion of the others. We must move forward in all four areas.

As many of you know, it is currently fashionable in Washington to say "let's put the health house in order before we do anything about financing," and this rather reminds me of Ring Lardner's famous line about the prize fighter: "His left wasn't very good, but on the other hand, neither was his right!" The people who take this position in the health field are saying "let's not do anything about the demand, while we don't do anything about the supply"--and the sorry history of appropriations for health in 1970 attests to this.

There are a number of significant proposals for national health insurance now being discussed. The problems will not disappear overnight under any program. I do not offer you a quick panacea; it's not nearly so important to predict the pace of change as it is to recognize the need for change, and to begin moving in new directions as they are tested and evaluated.

We do not believe that the solo practice of medicine and fee-for-service charges are divinely inspired ways of providing medical care, nor do we believe that any existing group practice prepayment plan will usher in the millenium. The organization of health care services needs constant tending. Our Committee is convinced that a program of national health insurance, which merely involves pouring more money into a fragmented and uncoordinated health industry,would only compound the acknowledged inefficiencies of Medicaid and Medicare legislation, and further inflate the cost of medical care. We are not in favor of pumping more money into the same system, even if it would provide some greater security and cost protection for the American family, and even if it did provide access to the same services to some additional people who today do not have equal access. We believe the time has come for establishing an integrated and coordinated system of health care that is available to all our people.

Let me mention some of the other things we do not favor. We do not believe in nationalized or socialized medicine. We do not believe the government should take over the hospitals and put doctors on salaries; we are against extending Medicare to other population groups, a few million at a time. Nor do we believe that the health professionals in our country should be compelled to reorganize and coordinate their fragmented services into a more efficient and less costly health care system. We do not believe in some higher order mandating hospitals out of existence.

But we do feel doctors can be persuaded, if financial and other incentives are written into national health insurance legislation, to test, evaluate and adopt better and more efficient health care delivery systems with built-in quality and cost controls.

We believe that health planning councils can be strengthened. Representatives of hospitals should have a voice in establishing policies that will spell out how decisions will be made for certifying the need for or granting a franchise for additional hospital or other health care facilities. We feel that budgeting is essential. We feel the budgeting principle should extend to the financing of physician's costs and all other health care costs, including those of the hospitals.

I would like to tell you about some other things we are for, but I must first report that contrary to recent stories in the press, we have not yet completed our work. A number of important issues remain under study by our technical committee. Technical sub-committees in the fields of dentistry and mental health are still at work on behalf of our group. Further attention is being given by the technical committee to aspects of hospital and drug benefits.

Several alternative proposals for financing are still being evaluated, but we have reached conclusions in a number of areas.

It has been our position from the beginning that health care is a matter of right, and that the way to help attain this right is through a financing mechanism whereby leverage can be used to bring about re-ordering of services--restructuring of services. The fact that we are for health care as a matter of right means that all persons residing in the United States should be eligible for benefits. There would also be buy-in arrangements including agreements for reciprocity for non-residents who are temporarily in the United States.

With respect to scope of benefits, we believe that all necessary services of physicians should be covered as well as all necessary services of general hospitals. One area that is still under study is that of dental care.

We believe that prescribed drugs should be covered--those essential to maintenance or restoration of health; appliances; and all necessary skilled nursing home care, but only in institutions that meet Medicare standards.

We have another subcommittee working in the mental health area. Our Committee feels that mental health problems should be actively dealt with. We are not for dumping mental health patients in hospitals and leaving them there.

All necessary home health services and such other services as laboratory work, professional services of optometrists and podiatrists, and ambulance services should be included in a good health care program.

We feel that more should be done to encourage hospitals to move into the area of providing care through extended care facilities and nursing homes after patients are past the critical stage where hospitalization is required.

More should also be done to extend home health services where the person needs health care but not the expensive facilities of a hospital.

Except in emergencies or when qualified specialists are geographically inaccessible, major surgery would be paid for under our program only on referral from a primary physician to a board-certified or board-eligible specialist, with the understanding that a physician who has been performing such surgery before the program starts could be certified if he is recommended by his participating hospital.

Independent laboratories would need to meet the federal standards now applicable to those doing interstate business.

All providers would agree to accept direct payment.

There would be no indemnity payments to patients.

Under our program federal legislation would establish basic standards for health care and eligibility to receive payment.

Now, moving on to systems of payment. Here's where we get to the budgeting concepts. We believe that health care cost budgets must be developed and we believe that hospitals should be paid on the basis of budgets developed by the hospital and approved in advance through the planning process at the local and regional levels. Budgets would be designed to cover the costs reasonably necessary under efficient operation of the services to be provided by the hospital. We believe that any financing mechanism must take into account the capital needs as well as those of manpower and resource development.

Primary physicians in individual practice could choose to be paid by fee-for-service, or on a capitation basis--or in some situations with a full-time or part-time salary, or some combination of salary and fee-for-service.

Comprehensive group practice organizations--and you'll see as I go on that our hopes for improvement of the system rely heavily on the development of more group practices--could choose to be paid either on capitation or a budget basis.

Our program would absorb Medicare; it would absorb the personal health service components of maternal and child health, crippled children's programs; it would absorb, in the sense of paying for, college and university in-house health care programs, neighborhood health centers and other personal health service programs of O.E.O. and H.E.W., health service aspects of vocational rehabilitation, health services provided in a few states that have temporary disability programs, etc.

Up to this point I have not mentioned Medicaid. We believe that Medicaid is a national scandal--a national disgrace. We would not be in favor of absorbing Medicaid as it is now operating. Our program would, however, relieve the states of some $3 billion of the cost of Medicaid, because the population covered for the benefits provided under this program would reduce the state's burden by that amount. The states would still have the responsibility for those benefits which go beyond our program--those which have historically been funded by the states.

From the outset our Committee for National Health Insurance has emphasized that a single nationwide program for financing medical care is essential for the reorganization of health care delivery and for the reorientation of providers. This would contribute to substantial savings in money and greater consumer satisfaction.

We believe that the national health insurance program should be financed by a combination of payroll taxes and general revenue funds. We have been thinking in terms of perhaps 60% coming from payroll taxes and 40% from general revenue. Today, federal general revenue taxes alone already pay for about 25% of the total private and public personal health care bill. A part of state and local taxes are also used for health. The program we are talking about would bring together most of the 25 or so separate health related programs in the federal government.

We estimate that the overall costs of our program would be about $40 billion a year, based on expenditures made for the services we propose to cover.

You may ask how we think our program could bring about the kinds of changes that we believe should occur. How will it move the system from where it is to where we think it ought to be?

One key element is what we describe as "front end" money. During the first year we would take 2% off the top of this program, or about $800 million, to establish a "special development fund." This fund would become operative before the benefits do--perhaps 9 months or a year before the benefits become effective.

We recognize that whatever financing mechanism is developed will have an important bearing on the availability of service. And this recognition will be reflected in the way we pay for services rendered.

I went to Washington seven years ago to join with the group that was working in behalf of Medicare. Those supporting Medicare considered it a humanitarian program. The records showed that the aged used 2½ to

3 times as many hospital days as the rest of the population, and all too often, when they reached 65 or retired, they were not allowed to stay in their health insurance programs. Even special efforts to spread the risk and provide special types of health insurance programs, such as New York 65 or California 65 or others, did not work out satisfactorily. Because of the limited income and assets of the aged, they could not purchase equal access to health services. Those of us who supported Medicare felt that it made a lot of sense to enable people to pay a bit each month into Social Security during their working lifetimes so that they could have equal access to medical care when they reached 65.

But that's not what we're talking about now. We're not talking about an insurance program--we're talking about a health program. We believe that you cannot separate financing from the organization for delivery of services. You cannot separate the restructuring from the financing. It won't happen by itself, and we believe that the work we have pursued for the last year in our technical committee will provide answers on how you structure your financing mechanism so as to produce a reform and a revitalization on the delivery side.

For a quarter of a century we have been polarized over group practice prepayment plans. Now a rapid de-polarization is taking place. But 25 years of rigidities prevented the testing of new forms of organized patient care. We have to learn by trial and error since the whole truth is not revealed to us. As we develop new arrangements for comprehensive, organized patient care, we need to evaluate each new program, not only in terms of cost but also with the criteria of effective organization, professional productivity and quality of care. Thoreau said a long time ago, "Build your castles in the air, but be sure they have foundations."

On the basis of the evidence gathered we are convinced that group practice programs will play an important role in providing coordinated, comprehensive family health care services for our nation.

We estimate that $40 billion should be available for payments to all providers of health care. This would be collected at the Federal level. The money, whether from payroll taxes or general revenues, would be comingled in a trust fund. It would be dispersed to ten regions, according to a capitation system, so many dollars for each person in the region, with some adjustments for consumer price levels and resources within the region.

But the real action would take place on the local level. From the regions, the funds would be distributed to local providers on the basis of allotments to physicians, hospitals, dentists, etc.

We believe that the various sections of the country should begin to develop new kinds of comprehensive care systems which will fit the particular needs of their communities, states, or region. One of the most interesting and encouraging efforts of this nature that I have heard about is your Eastern Montana Health Association. National Health Insurance could provide the funds--perhaps by capitation payments for each person residing in those 16 counties who elected to participate--to make this unique rural health system a working reality.

Because we feel there is abundant evidence that this form of health care delivery is more efficient, effective and economical, we propose incentives in the payment mechanisms that would favor physicians in multi-specialty groups or those who form such groups and accept capitation payments, and those consumers who voluntarily elect to receive their health care through the group. There would be similar incentives for hospitals and other health facilities which provide or establish comprehensive family care programs. But there would be no compulsion.

I hope you can see that what I have been describing is a health program and not an insurance program. We are interested in revitalizing the health care system, and not merely protecting people against the rising costs of health care.

Such a program could be administered through a Secretary of Health, if Congress saw fit to establish a separate department, or through the under-secretary for health in the Department of Health, Education and Welfare. This would be quite different from the way Medicare and Medicaid are administered, by the Social Security Administration and by the Social and Rehabilitation Service. We believe that this program should be closely related to and coordinated with other health programs supported by the government, programs that have to do with resource development, manpower development, medical research and so forth. A sound national health insurance program should not be separated from those other programs. It would not take over the functions of the Hill-Burton Act, for example, but would augment it.

We have a national emergency in the field of health services and resources, and we need a commitment through a trust fund approach to meet that emergency. In the 1950's we established a highway trust fund to meet the emergency situation on the interstate roads. Today's health care crisis demands an equal commitment.

Since our Committee was started in November 1968, we have received over 4,000 letters, many from physicians, and very few have been critical of our proposals.

As I travel to various parts of the country, I find that the concepts I have presented have considerable appeal, especially among young physicians and medical students. They see these as new opportunities in providing good health care.

I hope you, too, will see in these proposals some positive ideas for improving the availability and quality of health care for all Americans.

THE AMA POSITION ON NATIONAL HEALTH INSURANCE

by

Drew M. Petersen, M.D.
Chairman, AMA Committee on Community Health Care

The invitation I received to be on this program requested--at least by implication--that I give the medical profession's views on national health insurance--universal or compulsory or whatever you want to call it. I am going to get around to that subject, but I'm not going to begin with it, because there are subjects of greater importance when we consider the over-all problem, or challenge, or opportunity to bring the best medical and health care to all of the people in this huge nation.

Unfortunately for the public--very few of whom really understand or appreciate the complex situation--national health insurance is being held up by many political leaders, much of the press and others as the single cure for a multitude of problems. It's not. At best, it would solve one part of one problem.

Let's start with some background on our nation's medical and health care system--some of its achievements, and some of its problems. I think a little basic information will help us more clearly face the specific but narrow subject of national health insurance.

What about the much-debated medical and health care system? As a physician and as a holder of various committee positions in the American Medical Association, I have no choice but to say that it is inadequate to meet all the needs of this nation of 200 million souls. I neither excuse nor condone that inadequacy. But I do hasten to point out that it is not by any means unique. Regardless of what some of our critics like to claim, medicine is not the only field that has failed to function perfectly and universally throughout this land. It is true that some people do not have immediate access to the best possible medical and health care. It is equally true that they do not have direct access to the best possible legal services. They also do not have direct access to the best possible education, to adequate nutritious food, to decent housing, to elementary sanitation, to jobs good enough to provide an adequate livelihood for their families. I would add that not just a minority of our citizens, but the vast majority do not have access to drinking water that is as clean as it should be, nor to air they can breathe without danger.

Now let's turn to the medical and health care system. It needs improvement. It will be improved. But never to the point that you or I or the AMA will be satisfied with it. No matter how good medical and health care gets, people always want it to be better. That is particularly true of the medical profession itself, and its allies in the health care field. We who are part of the medical and health care system are always discontented with the status quo. If we hadn't been

in the past few decades, people would still be dying of smallpox, diphtheria, yellow fever, tetanus, typhus and polio--to mention just a few diseases that have just about been eliminated in this nation. The discontent of physicians with what they are able to do assures you that your life is healthier and better than your parents' was--and that your children's will be better than yours.

The biggest challenges of today, however, go beyond finding ways of curing disease or eliminating it. The scientific problems of medicine remain large, indeed, but they are almost overshadowed by the socio-economic ones. To show you what I mean, the AMA not long ago identified eight of the most pressing health problems facing the medical profession and the nation. The list could be longer, but it is long enough to give us plenty to think about. Here it is.

- First, the acute shortage of health manpower. That includes physicians and all other professionals, technicians and workers in the health care industry. That field is already the nation's third largest employer and will become number one during the 1970's.

- Second is the rising cost of medical and health care. That, like the shortage of manpower, has been caused by the fantastic growth in demand for services of every conceivable description--a demand that grew so fast and so great that neither the number of people nor the availability of facilities could keep up.

- Third is the problem of financing medical and health care. There are a number of possible sources, including the patient himself, private insurance, business and labor union programs, existing government programs, and any others that can be devised.

- Fourth is mental health. It continues to be the nation's number one health problem in terms of cost, use of hospital beds and human misery.

- Fifth is one that everyone seems to be talking about: pollution of the air, water and land of this country.

- Sixth, alcoholism and drug addiction.

- Seventh, health care of the poor in the inner cities, as well as of persons in isolated rural areas. Neither is adequately served by health institutions or personnel.

- Eighth and last of this list is malnutrition. Most people confuse that with hunger. Certainly it includes hunger, but since it also includes poor diet and poor eating habits, it is a problem that reaches into every social level and every level of income. It undermines the health of the fat rich man as well as the undernourished poor one.

When you look at all of those, plus others that could be listed, you must be struck, as we in the medical profession are, by the realization that none of them can be solved by any single program or activity, no matter how well it is devised and no matter how popular it may appear. Since this program is devoted to national health insurance, let's apply it to these problems. It doesn't touch seven out of the eight. If such a program were in effect starting tomorrow morning--if all medical care were free, if all medicine was free, if there were no charge for going into a hospital or nursing home--how would that affect the problems? It wouldn't create any more physicians, nurses or technicians. It wouldn't prevent people from having mental and emotional problems. It wouldn't clear up pollution. It wouldn't stop people from drinking or experimenting with drugs. It wouldn't make any more people or health centers available in slums or remote rural areas. And it wouldn't do anything about malnutrition.

All of those massive problems demand massive solution, and solutions will come only when the nation as a whole makes up its mind that they must come. Devising those solutions will then require the best efforts, the very best cooperative efforts, of everyone--the nation's people, its communities, its secondary educational system, its medical schools, its colleges and universities, its labor unions, its business and industry and its government--in addition to its medical profession and all of the organizations of all of the administrators, professionals, technicians and workers in the health field. Any program of national health insurance would, at best, affect only the third item I mentioned in that list of eight. It would affect the financing of medical and health care. For that reason--because the idea would help solve one of the problems--we are very interested in it. And we are not only interested in it; we are doing something about it.

The AMA, as a matter of fact, has developed its own program of national health insurance. It was adopted by our governing body, the House of Delegates, in 1968. We have been supporting it since that time and have had a few opportunities to present it to congressional committees. Most recently, early in March of this year, AMA representatives discussed the proposal at an executive session of the House Ways and Means Committee.

The AMA program that was born in 1968 had its conception approximately 18 months earlier when the Board of Trustees created its Committee on Health Care Financing. The committee's first function was to develop a few premises on which its findings should be based. I'm not going to list all of those guiding principles, but let me give you a few of the most important ones.

First--the simplest and most important of all--was that adequate health care should be available to all who need it. Alongside that was the statement that methods of financing should be developed to help all persons get the health care they want and need. Giving and receiving health care should remain predominantly private, with as little interference as possible with the relationship between patient and physician.

Methods of financing care should not limit the way the care is given, nor should it interfere with the patient's choice of where he shall get help, or from whom. Voluntary insurance purchased by individuals or through business and industrial groups should be encouraged. The government should not assume responsibility for people who can provide for themselves. To the extent possible, the system should use existing financing methods--Blue Shield, Blue Cross, insurance companies, group practice plans or other voluntary programs. The highest amount possible of all money spent in the program should pay for services. Administrative cost should be held to a minimum. Financing should be flexible. It should allow for money from both private and public sources. And finally, the financing system should be available to all of the public, not just to special groups.

The AMA's hope is to offer to the people--and to Congress for passage into law--a program that will do the job that needs to be done, and do it in a way that physicians know is the best way to cover the best possible medical and health care. We want to avoid the mistakes and problems that we feel were built into Medicare and Medicaid. Those are health care financing programs, but they were designed by politicians and administrators--not by physicians. And they work: they work because this nation's doctors have made them work.

We opposed Medicare for all the years it was a proposal, before it became law. Since then, we have been taking care of patients under its provisions. We opposed it primarily because it was to pay expenses for people who had reached a certain age, regardless of their own ability to pay. Medicare, in effect, takes the taxes paid by the file clerk and uses them to pay the hospital bill of the chairman of the board. We didn't think that was fair when the bill was proposed, and we still don't. We also warned everyone who would listen that the two programs--Medicare and Medicaid--would cost a great deal more than their supporters cared to admit. We were right. They had grossly underestimated the cost, which has run more than double what they promised--and is expected to double again in five years. That means the programs, which are costing taxpayers 10 billion dollars this year, will cost 20 billion by 1975.

Let me digress a moment here to point out that many people are now trying to defend the original planning of the programs by blaming the medical profession for the runaway costs. That simply is not true. The most recent example of trying to discredit the very physicians who have made the two programs work at all was a report on Medicare-Medicaid "problems, issues and alternatives," issued early this year by the staff of the Senate Finance Committee. I won't take your time for a detailed analysis of the report. But I do want to point out a few things it said that were incorrect.

The report indicated that the programs are riddled with fraud and abuse by physicians. No such thing. Are we, then, totally without fault? Unfortunately not. The Social Security administration has reported that 2,500 cases of suspected abuse have been investigated during three

and a half years of Medicare. And keep in mind that the program pays 30 million doctor bills a year and 12 million bills a year from hospitals and other institutions. So far, only 13 individuals and organizations have actually been charged with fraud. I'll put that record of honesty against the record of any group in this nation--or against the population as a whole.

The report indicates that physicians are responsible for the major portion of the increased cost of the programs. Examination of actual figures, including the consumer price index, shows that the increase in payments to physicians from 1968 to 1969 was less than 3 percent of the total federal expenditures for both programs. Some of that small increase was due to higher physician fees. Much more of it was caused by more people using medical services more often. If the two causes are divided, only 1.1 percent of the total federal expenditures for both programs in 1969 can be attributed to higher physician fees.

Other mistakes have been made in stories published since the report came out. A payment of more than $300,000 supposedly made to one Colorado physician was actually the total of all fees paid to 124 physicians at Colorado General Hospital. A California clinic was reported to have received $900,000. Actually, the payments went to 130 physicians who work in the clinic--an average of $7,000 per doctor. And that clinic takes care of three homes for the elderly. Finally, the physicians of Indiana were accused of milking Medicaid for huge sums of money in 1968. The fact is, Indiana did not have a Medicaid program until January of 1970.

We at the AMA--and a great many physicians, whether AMA members or not--have a strong feeling that you don't correct a complicated, overly expensive government program by expanding it to cover everybody in the country. Instead, you come up with a new idea, a program--a system of financing care--that will serve all of the people well, but will give special help only to the ones who need it. The people I know, inside and outside of the medical profession, just don't believe that government ought to pay the bills for people who can pay their own, whether for medical care, or food, or rent, or new cars or anything else. That's why we are offering our program. We call it our federal income tax credit system. Somebody at the AMA tagged it "Medicredit." The program is designed to provide voluntary, universal health insurance that is both attractive and available to everyone who needs it. And I think we can safely say that includes everybody.

Medicredit would use medical and health insurance policies or prepayment plans, such as Blue Cross and Blue Shield, from companies already in business. They would design and offer programs that would be available to every consumer. Remember, this is not a plan limited to any special groups. The special part of it comes in the premium payments for the comprehensive health insurance coverage.

For convenience, we've divided the population into three categories. First, persons who are unable to pay for health insurance. Second, people who can pay part of the cost, but not all of it. And third,

people who have enough money to pay for their own protection. The measure of ability to pay is related to income tax liability. Please note that I did not say gross or net income. The plan is based on actual dollars that must be paid to internal revenue--either by withholding or direct payment. The reason for using the actual amount of tax owed is that two families with the same income might vary a great deal in their ability to provide health insurance protection for themselves. One might have more children than the other, for example. Or one might have suffered casualty losses during the year, or have other financial reverses. And the lower the tax liability is, the higher is the credit provided for purchase of the insurance.

To show the workings of the program, we have arbitrarily chosen the figure of $300 tax liability for the bottom of the scale and $1,300 for the top. Our feeling is that the person or head of a family who owes less than $300 in federal income tax at the end of the year doesn't make enough to buy adequate insurance. For those people, Medicredit calls for the issuance of a certificate by the government. That certificate would be used just like cash, for insurance purposes only. It could be turned over to an insurance company, a prepayment plan or a prepaid group plan as the premium for basic, comprehensive coverage for medical and health care, in or out of the hospital.

For people with a tax liability between $300 and $1,300, there would be a graded scale of tax credit against the tax owed. For example, if you owed $400 income tax, the government certificate would cover 87 percent of the premium for the health insurance. If you owed $600 tax, the credit would be 59 percent. You would pay only the difference. The percentage paid by the government would go down as the amount of tax went up, indicating that your income was getting higher.

Finally, people whose federal income tax is $1,300 or more would get no credit. They are able to buy their own insurance protection, and could take advantage of the same comprehensive programs being offered by the insurance companies and prepayment plans.

The program also calls for a National Health Insurance Board, with representation from laymen, insurers and physicians. The board would define the basic coverage to be provided in the insurance programs and would oversee the operation of the whole program. All licensed insurers in any state could compete to provide the approved programs of coverage.

Now it is time I stopped. I do hope I can leave one major impression with you. The medical and health care system of this nation is a good one. It has not broken down; it is not falling apart; it is not riddled with graft, nor festering with incompetence. It is made up of men and women--human beings just like you--who are proud of their skills and dedicated to using them for betterment of their fellow men.

The system is, however, understaffed. It is crowded with patients, for whom it is doing the best possible job. It performs miracles now and then, in the spectacular cases that reach the newspapers. But mostly it just

goes along its way, doing a yeoman job of taking care of millions of people who need help--removing appendices, delivering babies, setting broken bones, giving medicine for the flu, binding up wounds, curing disease. Little or none of that generates national notice.

The furor comes about--and rightly so--because there are people in our huge nation--in its big cities, in its mountains, in its rural areas--whom the system does not reach as often as it should. There are people for whom it is too much of a burden to pay for the care they need. Nobody recognizes those weaknesses more clearly than physicians. And nobody is working harder to eliminate those exceptions to an over-all picture of good care for the nation. Along with many other concerned persons, we see a situation that must be changed. It is one that can be changed. But only by correcting a great many non-medical circumstances that contribute to the problem. There is no single cure.

SUMMARY OF REPORTS FROM DISCUSSION GROUPS

Note: Some of the topics and problems related to health were raised in more than one of the discussion groups. Conference participants did not necessarily attend the discussion group most closely related to their professional or occupational interest.

scussion Group #1: Business and Industry

Problems discussed included:

1. Distances from medical care (in many cases) and high costs.
   a. Possible use of helicopters and planes to transport patients to medical centers.
   b. Possible use of medical corpsmen, etc.
2. The problems small farmers face which make it difficult for them to keep on working as their health needs increase.
3. Resistance of industry to take a man back to work after he was partially disabled.
4. The high accident rate in some industries; lumbering and oil were discussed.
5. Alcoholism and heart attacks--the problems they pose for the employer as well as for the patient and his family.
6. The problem of absenteeism in business and industry--often related to colds, alcoholism, heart attacks, etc.
7. Air, water and soil pollution.
8. Occupational diseases and accidents.
9. Rising medical costs and insurance costs without comparable increases in benefits; problems of bribery, split commissions, etc.

scussion Group #2: Dentists

1. Manpower shortage in dentistry was considered the number one problem.
2. Proper distribution of dental manpower throughout the state was viewed as a serious problem for which no solution seemed at hand.
3. Greater emphasis should be given to preventive care. This would materially reduce the need for service, especially in the younger age groups. Dental neglect is expensive. With this in mind the group recommended the following for consideration:
   a. We see no reason for welfare or federal funds being spent in any community that has the ability to fluoridate its water and does not do so.
   b. Support legislation that would make it compulsory to fluoridate community water supplies.

c. Too often the mouth is "divorced from the rest of the body." If there is going to be a national health insurance program, Dental Care must be included.

d. There should be more emphasis on teacher training in dental health and more emphasis, when training hospital personnel, on the importance of dental health.

scussion Group #3: Disadvantaged (Low Income)

(No report submitted)

scussion Group #4: Farmers (Farm Organizations)

1. Inadequate availability of medical services seemed to be the most important problem facing many farmers. Many rural areas have only one physician, which means that if services are to be available the doctor would have to be on call 24 hours per day, seven days per week.

2. Many farmers have to drive long distances to existing medical facilities and even when they get there they often cannot get an appointment because of the long waiting lists.

3. Increasing medical costs, including high ambulance fees, make services difficult--if not impossible--to secure.

4. It was pointed out that there is increasing evidence that operating tractors and other machinery which emits loud, continuous noises is causing hearing defects.

5. It was suggested that legislation be enacted which would call for more safety devices on farm machinery--such as power take-offs, hay balers, etc.

6. Farmers and ranchers also face a health hazard from diseases transmitted by animals and from the dust of hen houses.

7. Easy availability of veterinary antibiotics has increased the number of farmers and ranchers who are "self-prescribing" for themselves and their families.

scussion Group #5: Government (Legislators, County Commissioners, Government Agencies)

1. There was some concern that government was trying to "sell" the concept of prepaid direct service plans. There was not full agreement that this is true but agreement that the problems encountered with Medicare and Medicaid point to weaknesses in the present system of health care delivery. It was agreed that health care is not available to all people.

2. Indians off the reservations have special problems in trying to get health care.

3. Some counties have refused to provide care for some medically indigent persons.

4. Some members of the discussion group felt that more money is often spent in checking on eligibility requirements than in providing health services.

5. Some felt that the seniority system in Congress contributes to an apathetic attitude toward the needs of all people. Some were concerned about agriculture being over-represented in Congress and the legislatures.

6. Issues which the discussion group felt should be considered by the 1971 legislature included:

   a. More money for Medicaid, to provide more comprehensive coverage.

   b. Financing a proposal for improving the delivery of health care in the state. Includes the need for more money for programs in colleges and universities to train persons in the health professions.

   c. Revisions in the WICHE plan which would enable Montana students to attend medical, dental and veterinary medicine schools in any state rather than being limited to the Western states. The question was also discussed of whether these students should be required to return to the state for a period of service or to repay the money spent on their education.

7. Innovative programs in medical education were suggested as possible means of attracting more physicians to rural communities in states like Montana with no medical school.

scussion Group #6: Indians

1. When Indians leave the reservations, where they have received health care without cost, they face a new situation where cost becomes a barrier to care. Without adequate funds for health care they rarely seek preventive care and often hesitate to ask for care in crisis situations. It was felt that too many health workers are not conscious enough of how sensitive many Indians are about their role in our society.

2. Many Indians as well as other consumers do not fully understand what is meant by adequate health care and do not know enough about the proper utilization of services that are available.

3. Indians, along with other consumers of health services, wish to be represented on panels and organizations discussing health care in the state.

Much of the time of Group #6 was devoted to discussing health problems of Indians who reside off the reservations. The group drafted the following recommendation:

"We urge Congress to appropriate sufficient funds for the Bureau of Indian Affairs and the Indian Health Service to finance full and adequate services to Indians residing off the reservation as well as those living on the reservation, whether they are Treaty or non-Treaty Indians and regardless of blood quantum, to the end that the United States meet its responsibility to the Indian people regardless of where they may live or work or what technical legal status they may hold."

scussion Group #7: Insurance Industry

1. The insurance industry must become involved in the systems of health care and concerned about health manpower.

2. Montana health insurance programs should provide community dual-choice programs.

3. Health insurance forms should be standardized.

4. More education should be provided on the economics of health care.

5. More preventive coverage should be provided--relying heavily on para-medical personnel.

6. The effects of liability coverage for physicians (malpractice insurance) should be examined since the costs affect the physicians, the patients and the insurance companies.

7. The insurance industry must be able to help meet the demands of consumers for services. Merely making payments after services have been provided is not enough.

cussion Group #8: Hospitals and Extended Care Facilities

1. Present government health care programs are still not adequate to meet many needs of the poor.

2. There is need to get more health services into remote areas of the state. Consideration should be given to first line health care programs as satellite extensions of larger hospital centers.

3. A study should be made of hospitals becoming involved in transportation or ambulance services for patients from remote areas or between facilities.

4. Hospitals cannot reject medically indigent patients who are not covered by a government health care program; therefore services and financial support should be considered for this group of people.

5. The problems of hospitals are so closely related to allied health care personnel and facilities that effort should be made to coordinate and integrate all more closely.

6. The level of care provided in many small hospitals is low and therefore there is a need for small hospitals to relate more closely to larger primary hospitals.

cussion Group #9: Physicians and Paramedical Personnel

1. To solve the problems of too few physical therapists in Montana it was suggested that auxiliary workers be used to a greater extent. At present there are only 38 physical therapists in the entire state. To train a P. T. Assistant takes two years while to train a P. T. Aide takes only

ten weeks. The latter can be trained in junior colleges but at present no such courses are offered in Montana. It was suggested that these workers should be licensed.

2. The Board of Medical Examiners tries not to be too rigid in their strict adherence to the Medical Practice Act, realizing that physicians in isolated areas may need to train other workers to assist them in surgery, etc. It was stated that the board knows that some of the provisions are not strictly adhered to but they feel that such a policy is necessary to serve a "practical if not ethical or legal purpose." The role of the paramedical person is increasing. Nurses have been making diagnoses for years. "It may serve some purpose to call a spade a spade." One physician stated that he thought a nurse could be used "in isolated areas" to do some of the patient sorting and patient care--similar to that which is being successfully done in some other parts of the country.

3. All ambulances should be equipped with two-way radios.

4. Clinical offices in remote areas could be manned by nurses, and physicians could visit those clinics at regular intervals (circuit riding physicians). The nurse should be able to communicate with the physician whenever necessary.

5. This discussion group felt that more effort should be made to communicate with high school students in order to identify those who might be interested in taking a two-year junior college course to become a medical assistant or medical technician but who are not interested in more training than that.

6. It was reported that a Missoula clinic has a Doctor's Assistant program where 18 persons have been trained to free both physicians and nurses for work that is more beneficial to the patient than explaining health insurance coverage. They could also assist with the technical aspects of proctoscopic and pelvic exams, pap tests, gathering urine samples, etc. This clinic has many more applicants than can be used in this training program. The person becomes a Doctor's Aide in much the same sense that there are Nurses' Aides. Such assistants make a real contribution in group practice.

7. It was suggested that the public's demand for more sophisticated medical care has been one factor in the present health manpower shortage. As more physicians have become specialists, more patients want to be treated by specialists.

8. Dr. Drew M. Peterson mentioned that the American Medical Association had proposed the use of 100,000 nurses as physicians' assistants and that this had raised some very strong feelings among the members of the American Nursing Association.

cussion Group #10: Workers (Labor Unions)

1. Part of the time was devoted to a discussion of the efforts of unions to negotiate better health and welfare programs for their members.

2. Workers and unions are naturally concerned about health hazards on the job.

3. Items not covered by most health insurance programs produce quite a drain on the worker's family budget.

   a. Dental care can be a major health problem in both old and young but is not considered as such--assuming that dental care is something that can be put off.

   b. The cost of eye examinations and glasses is high and is seldom covered by insurance.

   c. Drugs and medication are too often excluded by insurance.

4. It was pointed out that office hours for physicians and medical centers are such that workers can seldom go there without losing time during working hours.

5. The location of health personnel and facilities is such that persons like construction workers and oil workers in the drilling fields find it difficult to have access to care for anything other than emergencies.

6. The question was raised as to the extent to which seasonal workers are covered by health insurance on a year-round basis. It was felt that health insurance should be continuous.

7. Some members of the discussion group felt that if a program limited the choice of a physician this could become a problem for both the doctor and patient. "Not every doctor can treat every patient." (It should be noted that where there is either no physician or only one physician in an entire county, the freedom of choice is definitely restricted.)

HOW MIGHT THE PREPAID GROUP PRACTICE CONCEPT BE ADAPTED AS A "DUAL CHOICE" IN MONTANA?

by

Maurice J. McKay, Manager
Group Health Medical Center - St. Paul, Minnesota

Discussant: Walter H. Uphoff

Dr. Pratt: Mr. McKay, as you may have noted on the program, is manager of Group Health Medical Center in St. Paul, Minnesota. He has had extensive experience with group practice medical care programs, first with the Health Insurance Plan of Greater New York and, for the past nine years, with Group Health Plan in the Twin Cities. I understand that he grew up in Montana so he should be able to relate his experiences to the health scene of our state.

Maurice McKay: Dr. Pratt and friends in Montana, I say that because the first half of my 56 years were spent in this state so I have a kinship for the people of Montana and am delighted to be back here to discuss problems of health care delivery systems based on my experiences in the field. It was a pleasure to again see your beautiful mountains, to breathe some of your fresh air and to enjoy the sense of freedom you have in Montana.

I have not come to tell you how to operate your health services in Montana but to share some of my observations and experiences with you so that you can decide which ones might be adapted in your state. I have been closely involved with various kinds of prepaid health services for about 25 years. As a matter of fact, when I left Helena, Montana back in March of 1942 to enter the military service, I was heading up a small program under the National Youth Administration that was involved in health examinations and dental examinations. I am sure that early experience had some bearing on the career I chose to pursue. Actually, I had just completed my graduate work in Agricultural Economics at Montana State College and in those days you were glad to get any job you could find and I ahppened to get one with NYA. I felt very fortunate. I wasn't going to worry about the fact that the job wasn't directly in the field of Agricultural Economics but in a very short time I learned something of the health needs of youth between the ages of 17 and 25. There were great unmet needs at that time and I am sure there are unmet needs in Montana today, although I would guess that persons at this conference are not exactly representative of the state's population.

It appears to me that "health consumers" are in the minority here today. We should remind ourselves that health professionals tend to see the delivery of health care in a little different way than the so-called

"consumers" of health care-- the patients and the people who are the non-professionals. All of us have a vested interest. I, as the general manager of Group Health Plan in St. Paul and Minneapolis have a vested interest in the success and growth of prepaid group practice health care. I used to work for the Health Insurance Plan of Greater New York and when I worked there I tended to see my interests largely associated with that organization. Later, I worked for Group Health Insurance (GHI) in New York which was like a Blue Shield Plan and then I tended to see my interests associated with that organization. What I am suggesting is that none of us always see things entirely objectively. We see it largely in an institutional way and as it affects us and the people immediately around us. We should keep that in mind as we think about health care systems.

When we react with anxiety, anger or frustration toward a proposal we should ask whether we are responding primarily in terms of our economic and social interests rather than in terms of the public interest. If we don't adequately take the public interest into account, we are liable to have that great mass of non-professionals legislating or putting into effect a broad program of health care payment and delivery in which we can't have much to say. As a matter of fact, have we not already seen a good deal of this? Just the other day, Secretary Finch's office announced plans for a Part "C" of Medicare which, if enacted, will promote prepaid group practice across the nation in the next five years whether we like it or not. If this program is enacted it means that government has enough "muscle" to put it into effect. We should ask ourselves to what extent we want to go the voluntary route versus the legislative route. I happen to favor the former. I believe that the best system is one that permits a wide variety of programs to be offered and allows them to develop naturally within their respective communities so that we have a chance to test those systems and let the people observe them and evaluate them.

I recognize that a voluntary or private program can not meet all the health needs of our people, especially when it comes to high risk persons, those on welfare or low incomes, etc. The government has a role in the health field and we should work with it in determining what agencies or organizations can do the most effective job. I think I know Montana quite well even though I have been gone 28 years. I am one of 11 children; one didn't make it because my mother delivered without the benefit of a doctor at home. When I had an accident and needed emergency medical attention it took me about 8 hours to get to a physician. We nursed our own family through all the childhood diseases. We got by like rural families still do in many instances. The only thing that can be said for this limited type of care is that we didn't have many doctor or hospitals bills. The first time I was to hear about a doctor's bill was when a doctor came to deliver one of the last children in my family and we got a bill for $50.00.

Today in the Twin Cities we routinely pay about $500.00 for a 4-day stay in the hospital and $250.00 to the obstetrician. My mother never had any prenatal care or any post-natal care and none of the

children had any pediatric care. I don't propose that kind of a system today but people did live under it years ago.

Much of what we have in the way of a health care system is the result of what we, as professionals, feel we want and need. We're not always responsive to the public interest. We don't always provide the best programs. The doctor doesn't always think in terms of the patient, but I would like to add that as a result of many years of association with doctors, I have come to respect most of them as dedicated persons. They work hard. A great majority of them live by high ethics but they are inclined to see the problems in terms of the persons who come to their office. I can understand why this is so in a situation where there is a shortage of doctors in the country. As professionals, we do have a vested interest. We don't see things as the patient or the non-professional sees them. And yet, if we are to maintain a program of voluntary health care in this country we will have to take into account the point of view of the people who are non-professionals who are the great majority in our society.

I represent a prepaid group practice plan. I don't claim that is the only way to deliver health care but I surely think it is one of the better ways to deliver health care in this nation. It meets certain needs better than "fee for service" and I believe that those who try to impede the progress of prepaid group practice are, in fact, speaking out of self-interest which they try to turn around and couch in terms of the patient's interests. If we are to have a free society we must be willing to provide the enviornment in which the free instutions can operate and in which the natural course of events can proceed without having to fight the barriers of legislation and the barriers of all kinds of professional impediments. If we really believe in free instutions, if we really believe in free choice, then it follows that those among consumers and physicians who prefer prepaid group practice should have the opportunity to develop such programs.

For 25 years I have expereinced the "dug-in" resistance of a good segment of the medical community which as made it difficult to get hospital affiliation, to get doctors admitted to county medical societies and threats of various kinds which are totally inconsistent with the concept of freedom. Many of the physicians were incapable of talking calmly about prepaid group practice as they were about talking about sex within the family. When it comes to talking about medical practice, about a clinical diagnosis, doctors are among the most rational of men. They pile one bit of information on another bit of information. The good doctor usually comes up with an accurate diagnosis because he is a rational person who uses and assembles facts before reaching a conclusion. And yet, so often, that some doctor can not even touch upon the subject of the economics of health care--the delivery of health care, without becoming so emotional that he acts like one totally possessed by some outside influence. This emotional response is not limited to doctors. People in the insurance industry often respond emotionally when they feel, rightly or wrongly, that their position is threatened by any new program.

Now for some more specific comments about prepaid group practice in the United States as we find it today. Until recently, it developed rather slowly for a number of reasons. There was resistance on the part of the medical community and the other segments of the co-called "establishment", largely, I think because they had not really examined the concepts that govern such programs. Today, over seven million persons belong to such plans throughout the country so, you can see that the movement is growing even though it is thusfar much smaller than other types of health care delivery. Judged by numbers alone, it is not very significant as yet, but we are talking about the national mood and this is what we have to keep our eyes on.

For about eleven years I was with HIP in New York--one of the first major prepaid medical programs that serves almost a million people through thirty-one large medical centers. Then for several years I worked for Group Health Insurance which was like a Blue Shield Plan, paying on a "fee for service" basis. In fact, it was usually offered as a dual choice in conjunction with Blue Cross. I had an opportunity to evaluate the two systems and then I was invited to come to St. Paul to take charge of a very small, struggling program. At that time, Walter Uphoff who helped plan for this conference, was president of the board of Group Health Plan in St. Paul and had a part in persuading me to come to Minnesota. A number of University of Minnesota professors and others who could see the advantages of prepaid group practice care had decided to take a more active part in a program which had started when the membership was too small to be economically viable and was about $175,000 in debt and had few resources other than the interest and goodwill of its members.

When I came to St. Paul, we didn't know how we were going to meet the next payroll. Fortunately, I had sold my home before moving west and so I was able to carry my own salary for the first three months and during the next six months, I drew only half of my salary in order to help"keep the ship afloat." But it was the greatest experience I have ever had because I had a chance to work with the wonderful board members and members of the plan and the doctors, a really dedicated group of people. Believe me, it takes dedicated people to produce any program that's worthy of a good name.

After three years we saw some "black ink" and finally began to grow and since then we've been growing at the rate of about 25% per year. We've learned a lot about all the problems, all the stresses and strains, that fall upon a medical group, the pressures on the doctors, the pressure of budgets, etc., but we've grown with the enthusiastic cooperation of the membership we serve. We do not advertise. The plan is a non-profit organization in which the membership elects the board of directors. We also have a medical control board which concerns itself with all things medical. The board of directors is concerned with finances, its benefit structure and the general operations of the plan.

Let me tell you briefly about the type of benefits our plan provides. We now serve some 30,000 persons through two medical centers, having recently opened a new center on the west side of Minneapolis. Our

program provides: 1) office visits; 2) all specialist consultation; 3) check-ups for both adults and children; 4) eye examinations and 5) X-ray and laboratory care. In fact, we provide practically all out-patient services and this represents the major part of the services provided to members. We also provide in-hospital, full medical and surgical care. This includes maternity care both in and out of the hospital. We also have a pharmacy and we have an arrangement for providing glasses at reduced costs. Our hospital care is good for as much as 365 days of full board and room and special services in any hospital to which the patient is referred.

When our members happen to be outside of our service area, we provide an indenmity benefit similar to that provided by indemnity insurance programs. In a number of our contracts, we also provide for appliances, nurses' services, etc. This program is provided at a cost comparable to that of the Blue Cross and Blue Shield programs in Minnesota--between $36.00 and $40.00 per month per family. Our program does not make additional charges with the exception of drugs and eye-glasses and a small charge for home calls.

How our premium is used is very different from that of indemnity programs which have to spend a good share of their premium dollar on hospitalization and, thus, don't have as much left for out-of-hospital benefits. This should be of concern to all persons interested in health care costs and health care delivery. For example, our hospital program, which matches Blue Cross, requires about $17.00 per month per family and our medical services are about $21.00 per month per family. Blue Cross and Blue Shield (and, incidentally, they are often an option to our program with groups like the federal, state, city and university employees) spend their money quite differently. Blue Shield receives for their program about $11.00 per month and Blue Cross gets about $27.00 per month. The difference between the $11.00 that Blue Shield gets and the $21.00 we get ($10.00 more) goes to provide that broad program of out-patient care I have outlined, i.e., out-of-hospital specialty care, eye examinations, office visits, preventive care of all kinds, etc. <u>But</u> Blue Shield does not have that $10.00 and what seems to be happening is that the much higher frequency of hospital admissions and the longer stays that result from the other combination of benefits accounts for this significant difference in how the premium income is allocated.

You have, no doubt, seen the studies which show that in the prepaid group practice plans, among comparable populations, the hospital utilization is roughly half of that reported by Blue Cross and Blue Shield and commercial carriers like Aetna, Prudential, and other large carriers. If you can save 500 days of hospital care per thousand persons in one year, you have about $40,000 in the Twin Cities area to provide other health services. It is this saving that makes it possible for us to provide more complete out-patient care.

We do not contend that this is the only way to provide health care for everyone. In fact, for part of our membership we provide a "fee for service" option in our plan for the person who does not want to use

our clinic. We think it is a good program but we know that we can not provide the same number of services for the same money when those services are sought from individual doctors not associated with the program because we do not control the pattern of practices. Doctors who have been in "fee for service" practice have accommodated to a different pattern--more hospital admissions, fuller use of the hospital services, etc. I am sure they do it,in part, to take the pressure off the insured person because so many of them have plans that only cover them when they are in the hospital, or they may cover other medical costs only after a $50.00 or $100.00 "deductible" payment is made.

Insurance carriers have developed a variety of programs and we use a similar schedule of benefits for whatever members choose to go the indemnity route. We pay up to $800.00 for a brain operation. We use the California Relative Value Fee Schedule in determining payments. We pay for part of the costs of anaesthesia, hospital visits, etc., up to $1,000. We provide $150.00 for a normal obstetrical delivery. The hospitalization benefits are the same but under an indemnity program, the utilization is much higher just as it is with other carriers. As a consequence, we have only about $11.00 to work with for medical care as compared with $21.00 when we provide the services through our own medical center.

Prepaid group practice is one type of health care system. It has demonstrated that it is very fine for the people who like that kind of system and for doctors who like to practice under a group. For people who don't want to use it, it is a bad kind of health system and that is the way it should be. But, I hope that the people all over this nation will be generous enough to realize that people can buy good care and bad care, good food and poor food, go to good doctors and bad doctors and that, in the final analysis, they will permit the freedom to make "mistakes". I hope this concept can also be applied to the way we develop health care delivery systems. We must make more of an effort to get outside of ourselves and see the problems from the other person's point of view, for if we don't succeed in improving our health care systems voluntarily, we can expect national legislation which may or may not be to our liking. We've already seen what can happen in the case of Medicare and Medicaid. I'm not opposed to those programs but I'd like to see them "cleaned up". These programs represented a political compromise of all kinds of conflicting vested interest groups.

I realize the federal government will and must play a role, especially when it comes to raising funds for those who can not pay for their health needs, but I'd like to plead for as much voluntarism as is practical.

Walter Uphoff: Maurice McKay did a very good job of describing the problems that are encountered when you have to satisfy the interests of consumers and physicians in a program where you have voluntary choices. I would like to elaborate a little on the things he didn't have time to discuss and to say that the approach he has developed in Minneapolis

and St. Paul is unique. It is the only place in the country where members are entitled to "instant choice" instead of an annual dual choice. Having been a member of the plan Mr. McKay manages until I left to go to the University of Colorado in 1963, and getting back there from time to time, makes me feel that I am still a part of Group Health Plan. Because the plan there began on a very small basis, it did not have the economic or membership base to be in the "black" in the early years.

Group Health Mutual, an indemnity program whose leadership was committed to prepaid group practice, had between 6,000 and 7,000 members in the Twin Cities area. When the plan started, it was assumed that perhaps 2,000 of these might enroll in the plan during a 30day period but, apparently, the concept was too new and only about 550 persons wanted to switch which, together with about 150 who joined individually, meant that we had about 700 families when the doors opened at the center on August 1, 1957. The average age of the 550 who switched from Group Health Mutual was 58.5 years and you can well understand that the medical costs would be high for persons at that age.

Group Health Association of America which is a federation of these various prepaid group health programs, suggests that the minimum number you ought to have for starting a plan is 5,000 families. This means about 20,000 persons and at the rate of one doctor per thousand. This would require about 20 physicians representing the most called-for specialties. There have been plans which started with a smaller membership base and were successful. In Cleveland, Ohio they started with 3700 families and were in the "black" the first year so this is not an absolute figure but if you are going to have the full complement of services with the various major specialties represented, the goal of 5,000 families is realistic.

What I was talking about yesterday in regard to health centers or satellite health stations certainly does not fit this concept at all. What I was suggesting there was that in the more sparsely populated areas where you have a difficult time finding even 500-600 families to join together, the best you could hope for is a health center or a health team composed of several doctors, nurses, etc., who would be tied to one of the major clinics or centers. Together they could provide a better and more organized system of health care delivery than you now have.

Thanks to Maurice McKay's long hours and hard work, the program has become successful and has grown. He decided that the "dual choice" concept could be applied either before or after enrolling a group. Generally, in the group practice programs you have the group practice facility listed as a "dual choice" along with an insurance program. Either Blue Cross and Blue Shield for a private insurance carrier is the alternative program and perhaps, between 5 and 20% will elect the group practice prepayment program while the others will choose to have their premiums assigned to the existing or conventional indemnity system.

Then, after a year has passed and a reopening is provided you may find another 5-10% switching to prepayment. After a period of 4-5 years, Kaiser on the west coast, has found that usually between 35-50% will join their program and at least half will continue to choose the existing indemnity system for a variety of reasons. Kaiser will never take an entire group. They want only those who prefer this type of care and, therefore, always insist on a dual choice provision. Because Group Health Plan was one of a "family" of Group Health organizations, under the same roof, Maurice decided to take in an entire group and then give them dual choice afterwards. After a group was taken in, they were given the choice of coming to the clinic or going to their private physician. For example: If you come to the Medical Center where you have a team of doctors working together that freely refer patients back and forth on the basis of what seems to be wrong with them, with no fear of "losing a patient" because they are being paid to perform a service no matter how many or how few patients they see, you can expect to get appropriate medical care. Under that system, they can provide efficient and adequate health care because hospital utilization is down. There is no incentive to unnecessarily hospitalize a patient if the person's health care is covered outside of the hospital. If the person is not covered outside the hospital, the pressure to be sent to a hospital will be greater. This is the most important single factor in the rising costs of health care.

What Maurice has worked out is a program where a member has "instant choice" on an illness-to-illness basis. He can either choose to go to the Group Health Medical Center and get direct service coverage or he can go to any physician of his choice and be covered by an indemnity schedule, similar to that provided by Blue Cross and Blue Shield. If he should choose to go the latter route, he must be prepared to pay any supplemental charges for items not covered by the policy.

Because there is no control over the number of procedures and X-rays ordered when you go to an individual doctor, quite obviously, there is no incentive for keeping costs down as long as it is assumed that insurance will cover a good share of the charges. However, the higher costs must be incorporated in the premium structure for the following year. That is why the person choosing the indemnity route may be forced to pay 30% extra on his medical bills--while the person who comes to the clinic for care has no extra costs--except for drugs and eyeglasses, etc., which, of course, also are extra for those who choose the indemnity route and, at a higher rate.

The question we are concerned with at this conference is--how much of this concpet of prepaid group practice could be adapted to the situation in Montana and how many consumers and physicians would be interested in this type of health care. I tried to incorporate and adapt the basic concepts which Mr. McKay discussed, in the "model" which I spoke of earlier in the conference. The persons at this conference and others interested in health care delivery will have to decide how much will fit their situation and how much they would like to adapt in their communities. All we can do is suggest the kinds of guiding principles that seem necessary for success.

One of the basic tenets of this type of program is voluntarism or "dual choice". Consumers and providers of medical care must both be free to join or not join this type of program. Persons promoting the prepaid group practice concept realize that net incomes must be comparable to those in other forms of practice (after considering hours, investment in equipment and facilities, etc.) if such programs are to attract and keep competent staffs. When you look at the salaries paid to physicians working in prepaid group practice programs, you find that most of them are paid between $25,000 and $35,000 per year--plus fringe benefits such as a good retirement program, time off for attending medical education programs, etc. and they have no responsibilities for renting facilities, buying equipment, hiring secretarial and nursing staff personnel, etc. They are free to practice medicine, the thing they are primarily trained for.

QUESTIONS AND ANSWERS

Panel Members: Jack Carlson, Fred Holbrook, James Kent, Maurice McKay, Dr. John Strizich and Walter Uphoff

Questions:

Question from Audience: How important does the panel think it is to establish a health facility in a rural community with about 2000 permanent residents and about 340 tourists per day during the summer months - with the nearest doctor from 50 to 90 miles away?

Comment from Panel:

James Kent: The panel has not discussed this specific question. I would say that you have to look at what kinds of health resources are available now and then determine what might be added. You might have to consider developing a health plan that includes a mobile unit backed up by closed circuit TV with a doctor in a central location, in addition to whatever medical and paramedical personnel can be brought together. I am not sure how best to handle the health needs of a transient population such as your tourists.

I realize that in order to develop an adequate medical program you have to have an adequate economic base and I think more attention must be given to all the problems of the community, - jobs, education, roads, etc. - so that a viable health program can be developed. I am not sure how best to handle the problem of health care for transients, unless some payment or premium for health care were paid for each person who enters the area, which would then entitle him and his family to necessary care - within the area, if the care needed is available in the area, and referral to specialists and hospitals when needed.

Fred Holbrook: Our discussion group did conclude that we need more health care in remote areas and that we should consider satellite extensions of hospitals. It was also suggested that we should look at the transportation problems that would be related to such remote satellites.

Question: Can the committee that planned this conference be continued to help solve the problems of health care delivery in Montana?

Dr. Pratt: It seems to me that the Office of Comprehensive Health Planning and its Advisory Council would be directly involved in any continuing planning that takes place. The problem is really one of determining ways and means of implementing programs and having the necessary resources to do so. The next question which was sent up to the panel asks for comment on how a voluntary prepaid group practice program would deal with the problems that the Veterans' Administration and the Indian Health Service encounter when they run out of money and still have unmet health needs. I think this question should be directed to Mr. McKay.

Mr. McKay: I have not worked for either of these government agencies but I can tell you how we deal with that problem in our organization. Naturally we have to balance income and expenses, staff and consumer needs. We have to develop a schedule of benefits that is realistic within the rate structure we have. If an organization runs short of funds, it must either raise the rates or curtail services. We make it a point to take care of all the health needs that are called to our attention. We have had to spread such services as eye examinations and physical check-ups over a period of time - just as is the case in the rest of the medical community. But we tell our members, "Do not wait for a physical check-up if you have a health problem." Health problems are given first priority and check-ups are worked into the overall health program as time permits.

Question: How often are fee schedules and benefits structures reviewed or adjusted?

Jack Carlson: I can answer that question, but only from the vantage point of someone who is involved in administering a public program namely, the medical part of our welfare program. We always have to negotiate our schedules within the limitations of our appropriations. We try to get them close to what is provided for under a Blue Cross and Blue Shield schedule. We are limited by the budget assigned to us. We have revised fee schedules within the framework of available funds.

Question: Would it be a little more economical for an already going concern, such as Blue Cross and Blue Shield, to develop a viable program than to develop a new program with all that that entails?

Walter Uphoff: In the "model" proposal I presented, this is one of the very points I tried to make. I suggested that we ought to start with as many programs and agencies as are willing to cooperate and try to get them to fit into the growing and changing needs of society. I made reference to the fact that in Wisconsin Blue Cross right now is in the process of working with several communities in developing prepaid group practice programs. This is a new development and I am glad to see it come. Five years ago you would not have heard of such developments, but things are changing and I am glad to see so many organizations with a flexible enough program to consider new approaches when indicated. My answer would be, by all means, work with existing institutions in so far as possible in developing new programs. If they are adamant and resist change you may have to try some other approach but I would certainly not embark on such a course without making every effort to involve existing agencies.

Jack Carlson: In our program we have made every effort to have medical care provided in Montana in a way that best fits the Montana situation. We've exercised certain options with the Federal legislation. Rather than add additional staff to process claims, which might have required 30 additional persons, we adopted a program of having Blue Shield do this on a per claim basis. At the beginning of the program when the volume was small, the charge was $1.04 per claim. At the present time it is down to $0.66. We have allowed maximum use of the services we have been able to provide within the structure of the program.

Dr. Pratt: I am going to direct the next question to Dr. Strizich. The questionner states, "I do find an inconsistency on the part of the doctors who talk about how terribly busy they are, saying that they are incapable of taking on more work, yet who complain that the health officer, who provides certain services "for free" should be reprimanded by the local AMA for taking "business" away from the local doctors. How do you explain this?"

Dr. Strizich: I personally have no objection for using public funds for vaccinating children under almost any circumstance. As a matter of fact the local medical society in Lewis and Clark County, along with the local nurses, cooperated in vaccinating all the children in the county at a cost of somewhere between 25 and 30 cents per shot of the vaccine. I do think that many of us raise serious objections when services are provided to persons who could well take care of their own needs.

Dr. Pratt: There is a second part to the question and that should perhaps be answered by Dr. Anderson, Executive Director of the State Department of Health. The question is, "Why are county health officers not supported when such controversies arise?"

Dr. Anderson: I think the question really asks, "Why did we not go to the community in question and support the county health officer?" I assume this question is related to an issue which was raised in Missoula. It pertains to a situation which happened in Missoula where there was some question as to the proper function of the Missoula County Health Department in providing services which had to do with maternal child

health, immunizations and other things. There were some physicians who raised questions as to why these services were being provided through the health department when they could be provided through their own offices. A very wholesome public discussion followed. It is my impression that the Western Montana Medical Society did support these types of services and that they are still being provided. I did not go to Missoula because we adhere to a policy of not going to a place unless we are invited. I happen to believe that the county health department was making good use of tax funds and its programs should be continued.

Comment from the Audience: It is my feeling that the medical society did not totally support the public health program in Missoula. I understand that the medical society took the position that it would permit a continuance of the program providing there was no expansion and providing the person was unable to get these services elsewhere, putting the burden of proof upon the health department rather than on the individual as to whether it was a low income person. This would mean having the person tell the county health department, "I can't afford to go to the doctor, can I get a shot for my kids?" I think this type of service should be available to all children.

Dr. Pratt: Is there anyone here from the Western Montana Medical Society who would care to comment on this?

(Voice not identified): Dr. Pratt, I don't want to represent myself as a member of the medical society, but I am a member of the Missoula City-County Board of Health and have followed this matter from the beginning. Much of the problem stemmed from the misunderstanding that was the result of inadequate communication. (Note: Since the discussion on this issue was long and related to the problem in one county, the details have not been included in this summary.)

Dr. Pratt: I am going to direct the next question to Dr. William F. Cashmore (Secretary of the State Board of Medical Examiners). "Is there a possibility of using more foreign trained doctors and nurses in Montana?" We know that Warm Springs State Hospital has a number working there now.

Dr. Cashmore: Of course there is that possibility. There are some well-trained physicians. We have licensed several of them. We have put them under a temporary license because there is a requirement that they be citizens before we give them a full license. Our experience, frankly, has not been good. We have some foreign trained doctors who are performing well, but much of the difficulty arises out of differences in their cultural, religious and political backgrounds which makes it difficult for them to be assimilated in the community.

We are a bit alarmed that we are not getting the number of applications from physicians we should have to fill our needs, especially in the field of general practice.

At the moment we have more applications from foreign physicians than we have from American trained doctors. We also find that about 4/5

of our applicants are specialists. We get entirely too few applicants who want to go into general practice in the smaller communities.

Some of the ideas that have been expressed at this conference have a great deal of merit. I am all for up-grading the training and skills of the paramedical personnel providing it does not lead to giving a certificate which implies that these persons are now "full-fledged" doctors. As all of you know, who are physicians and all who are patients, it is often difficult enough for a well-trained doctor to make the correct diagnosis.

Dr. Pratt: Several more questions on prepaid group practice plans have been submitted. I have turned them over to Mr.McKay for comment.

Maurice McKay: The first question is, "Has prepaid group practice coverage ever been extended to those from 65 to 95 years of age?". We cover people of all ages. Once they are in the plan they can stay with us, regardless of age. We don't go out and enroll people over 65 who are covered by Medicare, however.

The next question is, "Does Mr. McKay's plan cover persons who are mentally retarded?". The answer is "yes". They have the same rights as others. When special provisions are called for they are similar to those of Blue Cross and Blue Shield and other insurance carriers.

A third question reads, "How or where could your plan work in Montana?". I would say that the program I have described could work any place in Montana. Such a program would, obviously, rely heavily on the type of indemnity I have described but would also permit a dual choice for prepaid group practice. I think there are some excellent groups in Montana, especially in the major cities. These groups could establish prepaid group practice as an option with out-reach provisions and do things that they could never dream of doing on a strictly indemnity basis. Many of the things that you can do when you have a fixed population can't be done under an indemnity program where the people are committed to no particular program and can go from doctor to doctor and from health facility to health facility. You can't work out a program for them. Therefore, I think that the fine groups already in existence in Montana and some of the fine general practitioners, who could set up an extension of their work with public health nurses and other out-reach methods, could do tremendous things to improve health care delivery. If you could do more in the way of preventive care, over and above physical check-ups, you would bring into being the kind of health care system that would provide continuity of care through an orderly and efficient system.

SUMMARY AND EVALUATION

by

Dr. Sidney C. Pratt, M. D.,

Director, Montana Regional Medical Program

It is impossible to condense into a few minutes all the interesting, significant and relevant points made during this two-day conference. You all heard the fine statements, starting with the knowledgeable and relevant welcome by our Lieutenant Governor, Tom Judge; the keynote address by Dr. Hogness; the comments by the panel on the status of health care in Montana; the message of Congressman Melcher and Mr. Uphoff's "model" proposal.

Most of you took part in the discussion groups where there was ample opportunity to explore problems that concerned one or more of the participants in the group. Last evening you heard two points of view on national health insurance by Mr. Max Fine and Dr. Drew Peterson. Today, you heard the reports from the ten discussion groups and the presentation by Mr. McKay on how the prepaid group practice health plan in St. Paul and Minneapolis functions and many of you had a chance to ask questions of the speakers or to add your comments to what was said.

If you have additional suggestions or comments, I hope you will write me. I will then share these comments with the Comprehensive Health Planning group and all the other individuals who were involved in this conference. The whole subject we have been discussing for the past two days is much too important to let drop at this point. We are not a problem-solving group, this panel is not a problem-solving panel, you, the conferees, were not problem-solving participants. The function of this conference was to identify the problems and come up with some potential answers that may be of help in solving the health problems of our state.

I would like to make a few observations about the ideas expressed at this conference. It was brought out in one of the discussion groups that there is a distinct lack of communication between various groups and various individuals, whether these groups be cultural, social, professional or ethnic. We seemed to have difficulty seeing the problems from the vantage point of the other person. Perhaps this is one of the reasons we have some of these problems today. All too often, two-way communication does not exist. We are not comparing ideas when we allow others to speak for a moment or two so we can jump in with our retort without ever really hearing what the other person had to say. Dr. Hogness pointed out that even though we do have highly trained health professionals, they are not universally available to the people when and where needed. Our goal should be to have adequate health care more universally available to all of our people. Dr. Hogness stated that our health system is, in essence, a variety of sub-systems, involving delivery, medical training, education of health professionals, etc. He pointed out that much in our system of organized

medical practice is out-of-date. The system we have needs improving. We give lip service to the concept of a "health care team" but, unfortunately, there is not much teamwork.

Because our health problems are so great, they require more than one health professional to give all the care that is necessary. It was pointed out that entry into the health care system is difficult for many. The fact that some form of national health insurance is likely to be adopted in the future, raises the question of how and to what extent we can and should be involved in the planning and operating of such a program. Dr. Hogness also stressed the need for change in medical education and in training all health professionals.

Dr. Strizich came out with a most important comment, namely, that all members of our society should contribute to the solutions of the medical and health care problems. It is not just the problem of the medical profession or the health care recipient, but of all groups in society. Mr. Kent, representing the consumer viewpoint, pointed out, very wisely, that health is only a part of our total concern. Systems of health care should be directed toward the enviornment of those involved. Health is just one aspect of a person's total enviornment. Economics is also important.

I would like to make several final observations: Some statements made during the conference would imply that everything related to health care in Montana is bad. I feel that health care in Montana, generally, is good. I think that there are many dedicated individuals working in medicine, nursing, in hospitals, in laboratories and in all branches of the health field. What we have to do in Montana is make the health care system even better. We should remind ourselves that not only are the recipients of health care people, but so are the providers of health care. We should be aware of the viewpoints of all the people who have an interest in health care, be they consumers, providers, insurers or taxpayers.

Action taken at this conference calls for having the Office of Comprehensive Health Planning try to make arrangements for having a summary of this conference published for distribution to those who attended the conference, to leaders in government and in the health professions. We hope this conference will lead to further action and that it was another significant step toward better health care in Montana.

CONFERENCE SPEAKERS AND PARTICIPANTS

Total Attendance - 134

Speakers:

Jack R. Carlson, Director, Division of Medical Assistance, Montana Department of Public Welfare
Max W. Fine, Executive Director, Committee for National Health Insurance Washington, D.C.
John Hogness, M.D., Executive Vice-President, University of Washington, Seattle, Washington
Fred K. Holbrook, Administrator, Montana Deaconess Hospital, Great Falls
Thomas Judge, Lieutenant Governor of the State of Montana
James Kent, Foundation for Urban and Neighborhood Development (FUND), Denver, Colorado
Maurice J. McKay, Manager, Group Health Medical Centers, Minneapolis-St.Paul, Minnesota
Hon. John Melcher, Congressman, Eastern Montana District
Drew M. Peterson, M.D., Chairman, AMA Committee on Community Health Care, Ogden, Utah
John Strizich, M.D., Member of Montana State Board of Institutions, Helena
Walter H. Uphoff, Professor of Economics, HEW Project Director, University of Colorado at Boulder

Participants:

Colvin H. Agnew, M.D., Director, South Central Areawide Health Planning Council
F. John Allaire, M.D., Great Falls Clinic
Allan Anderson
John S. Anderson, M.D., Executive Officer, State Department of Health
Delores Barsanti
Grace Bates, Areawide Representative
Dick Benz, LIGHT Representative
Perry M. Berg, M.D.
Helen Bertelson, Regional Medical Program
Doris Bishop
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Tryg Brensdal
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Willard Brown, Acting Regional Program Director for Community Health Services, PHS-HEW Region VIII, Denver, Colorado
Dr. John Buchness, Regional Health Director, PHS-HEW Region VIII, Denver, Colorado
Mrs. Tony Burgmoier, R.N.
Paul Carpino, Director, Community Action Program (CAP)
Theodore Clack, Research Analyst, Comprehensive Health Planning Office

Participants (continued):

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Milo E. Dean, County Commissioner
David R. Depew, Community Planning Consultant, Comprehensive Health Planning
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Dick DeRosier
L.A. Dombey, LIGHT Representative
Mrs. L.A. Dombey, LIGHT Representative
M.E. Donovan, Montana Physicians' Service
Mary Edna Earls
Doris N. Eklund, R.N.
David H. Farnham, M.D.
Edna Frey, LIGHT Representative
Marge Goering
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C.L. Harrington, City Attorney, Butte, Montana
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Clyde Jarvis, President, Montana Farmers Union
Robert R. Johnson, Acting Director, Montana State Office of Comprehensive Planning
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Glenn Kinsley, LIGHT Representative
Arthur F. Kussman, Director of Information and Referral Project
M. Laine, D.D.S.
Bill Lannon, Assistant Executive Officer, University System
Esther Lantz
Bertha LaPier, LIGHT Representative
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Bill Leary, Executive Director, Montana Hospital Association
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Leon M. Wallace, Director, Veteran's Administration Center

Participants (continued):

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Pete Welsh, LIGHT Representative
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